



2019 MARCH OF DIMES REPORT CARD

HEALTHY MOMS. STRONG BABIES.

[MARCHOFDIMES.ORG/REPORTCARD](https://marchofdimes.org/reportcard)

POLICY **ACTIONS**

MARCH OF DIMES REPORT CARD RECOMMENDED POLICY ACTIONS

March of Dimes 2019 Report Card monitors progress on key indicators and actions to improve the health of moms and babies in the U.S. Overall, the rates of maternal death and premature birth (the leading contributor to infant death) are increasing. In specific states and among specific racial and ethnic groups, policy changes have brought about improvements. March of Dimes recommends the following policy actions for all states. Any policy should be rooted in addressing disparities in maternal and infant health outcomes.



1. PROTECT COMPREHENSIVE HEALTH CARE COVERAGE FOR MOMS AND CHILDREN

Almost **90%** of U.S. women will give birth during their reproductive years.¹ They all need access to quality prenatal, labor and delivery and postpartum services to help prevent and manage complications. It's imperative that health plans continue to offer the 10 categories of Essential Health Benefits, including maternity and newborn care, well-woman and well-child preventive care, prescription drugs and mental health services, which are critical to the health of both mom and baby. Lawmakers must also preserve existing consumer protections regarding pre-existing conditions and shield families from high premiums and out-of-pocket costs and lifetime or annual limits.



2. PROVIDE AFFORDABLE, QUALITY PUBLIC HEALTH INSURANCE PROGRAMS TO WOMEN BEFORE PREGNANCY, AN ESSENTIAL TIME TO INTERVENE TO ACHIEVE HEALTHY PREGNANCIES

Research shows one of the best opportunities to achieve healthy pregnancies is to improve the health of all women before they become pregnant. Medicaid expansion to cover individuals up to **138%** of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

The uninsured rate for women of childbearing age is nearly twice as high in states that have not expanded Medicaid

16% vs 9%

compared to those that have expanded Medicaid (16 percent vs. 9 percent).²

¹Pew Research Center. They're Waiting Longer, but U.S. Women Today More Likely to Have Children Than a Decade Ago. Available at: <https://www.pewsocialtrends.org/2018/01/18/theyre-waiting-longer-but-u-s-women-today-more-likely-to-have-children-than-a-decade-ago/#fn-24248-1>. 2018.

²Georgetown University Health Policy Institute, Center for Children & Families. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Available at: <https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/>. May 2019.



3. EXTEND MEDICAID COVERAGE FOR POSTPARTUM MOMS

The latest data shows that one-third of all pregnancy-related deaths happen one week to one year after delivery.³ In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist. Comprehensive health care coverage in Medicaid should be extended to at least 12 months postpartum.

55%

of moms who were insured by Medicaid for their delivery were uninsured six months after giving birth.⁴



4. IMPROVE MOM AND BABY HEALTH THROUGH EXPANSION OF GROUP PRENATAL CARE

Studies demonstrate that group prenatal care reduces premature birth among Black women by **41%**, and among women of all races/ethnicities by 33 percent, in addition to other health benefits for both moms and babies. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.



5. ADVANCE OUR UNDERSTANDING OF THE CAUSES OF MATERNAL DEATH

In order to implement strategies to prevent maternal death, we need to understand why moms are currently dying before, during and after pregnancy. Maternal mortality review committees (MMRC) investigate every instance of maternal death in a state or community, and make recommendations to stop future tragedies. We must continue to support the work of state MMRCs to collect robust and standardized data to inform local and national policies to address the nation's maternal mortality crisis.



6. ELIMINATE RACIAL DISPARITIES IN HEALTH OUTCOMES FOR MOMS AND BABIES

Black, American Indian and Alaska Native women and their babies consistently have worse health outcomes than their white peers. Implicit bias training for health care providers and increasing access to and coverage for doula services are among the many strategies to fight unacceptable disparities.



7. REMOVE BARRIERS TO OBTAINING QUALITY CARE IN UNDERSERVED AND RURAL COMMUNITIES

Each year in the U.S., approximately **150,000 babies** are born to moms living in maternity care deserts or communities without a hospital offering obstetric care and without any obstetric providers.⁵ Women in these communities may have difficulty getting appropriate and quality care before, during and after pregnancy. Increasing access to inpatient obstetrical facilities and qualified obstetrical providers, including Certified Nurse Midwives, Certified Midwives and midwives whose education and licensure meets the International Confederation of Midwives standards, is critical to improving outcomes in these communities.

³Centers for Disease Control and Prevention (CDC). Pregnancy-Related Deaths. Available at: <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>. May 2019.

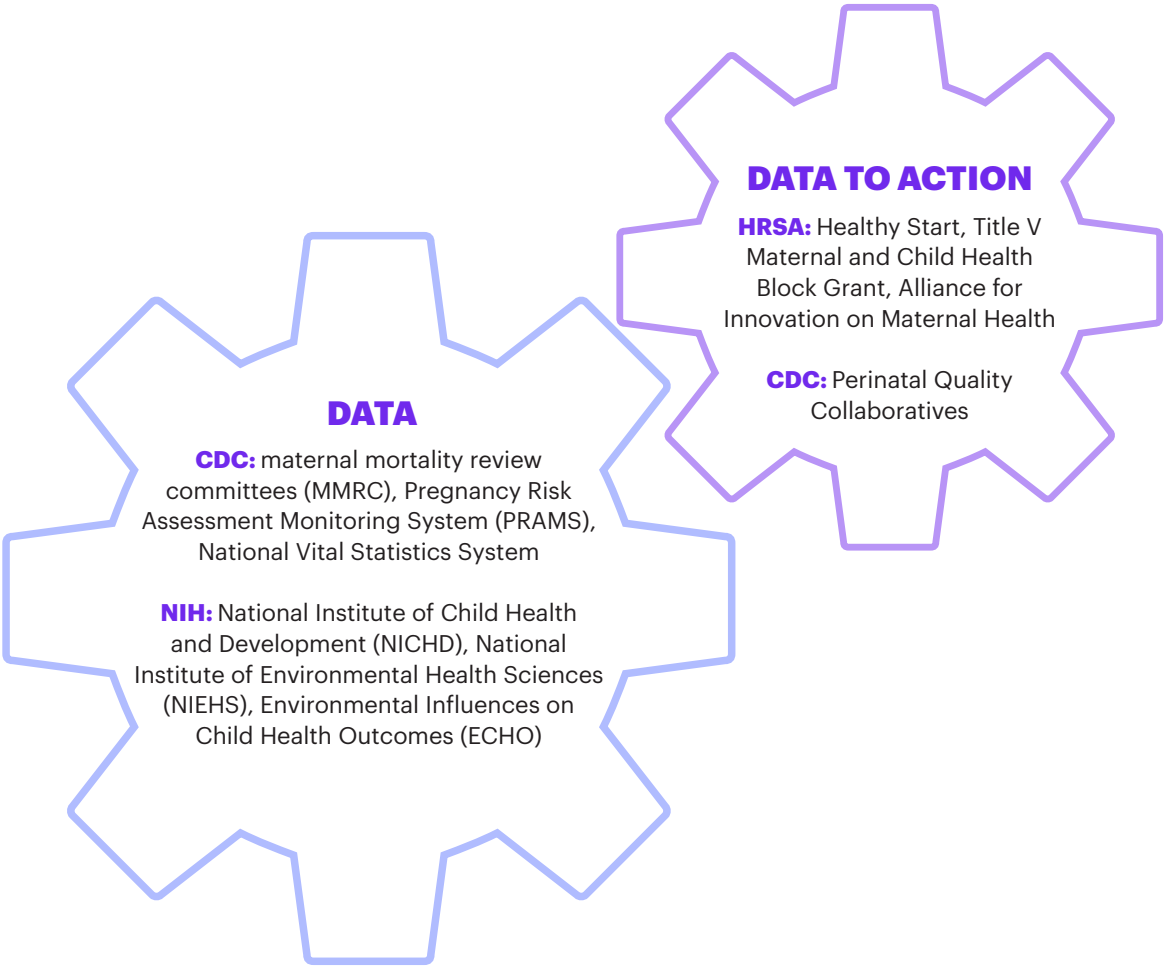
⁴Daw JR et al. Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth. Health Aff 2017 Apr 1;36(4):598-606.

⁵March of Dimes. Nowhere to Go: Maternity Care Deserts Across the U.S. Available at: https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf. 2018.



8. INCREASE INVESTMENTS IN VITAL PUBLIC HEALTH PROGRAMS TO PROMOTE HEALTHY MOMS AND STRONG BABIES COMMUNITIES

Population-level improvements in maternal and infant health rely on a robust public health infrastructure to detect contributors to poor outcomes, identify opportunities to address those contributors and then mobilize providers, health systems, stakeholders and communities to take action. We must support efforts to improve data on maternal and infant health and bolster programs focused on implementing strategies that have shown to keep all moms and babies healthy.



LEGEND

	Women affected
	Pregnant women affected
	Baby affected



2019 REPORT CARDS

2019
MARCH OF DIMES
REPORT CARD

This year, in addition to monitoring progress on key indicators, Report Cards include selected state actions to improve maternal and infant health. Premature birth and its complications are the largest contributors to infant death in the U.S., and preterm birth rates have been increasing for four years. Prematurity grades are assigned by comparing the 2018 preterm birth rate to March of Dimes' goal of 8.1 percent by 2020. While it's not yet possible to assign grades for maternal health indicators given the available data, it's clear that rates of maternal death and morbidity are unacceptably high. Maternal health complications, and the social determinants of health, affect the health and survival of both mom and baby. Highlighted on the second page are selected actions available to states to help improve maternal and infant health.

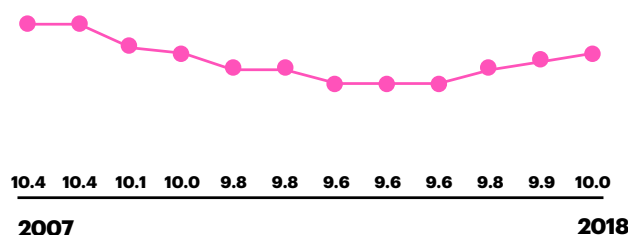
UNITED STATES

PREMATURITY
GRADE

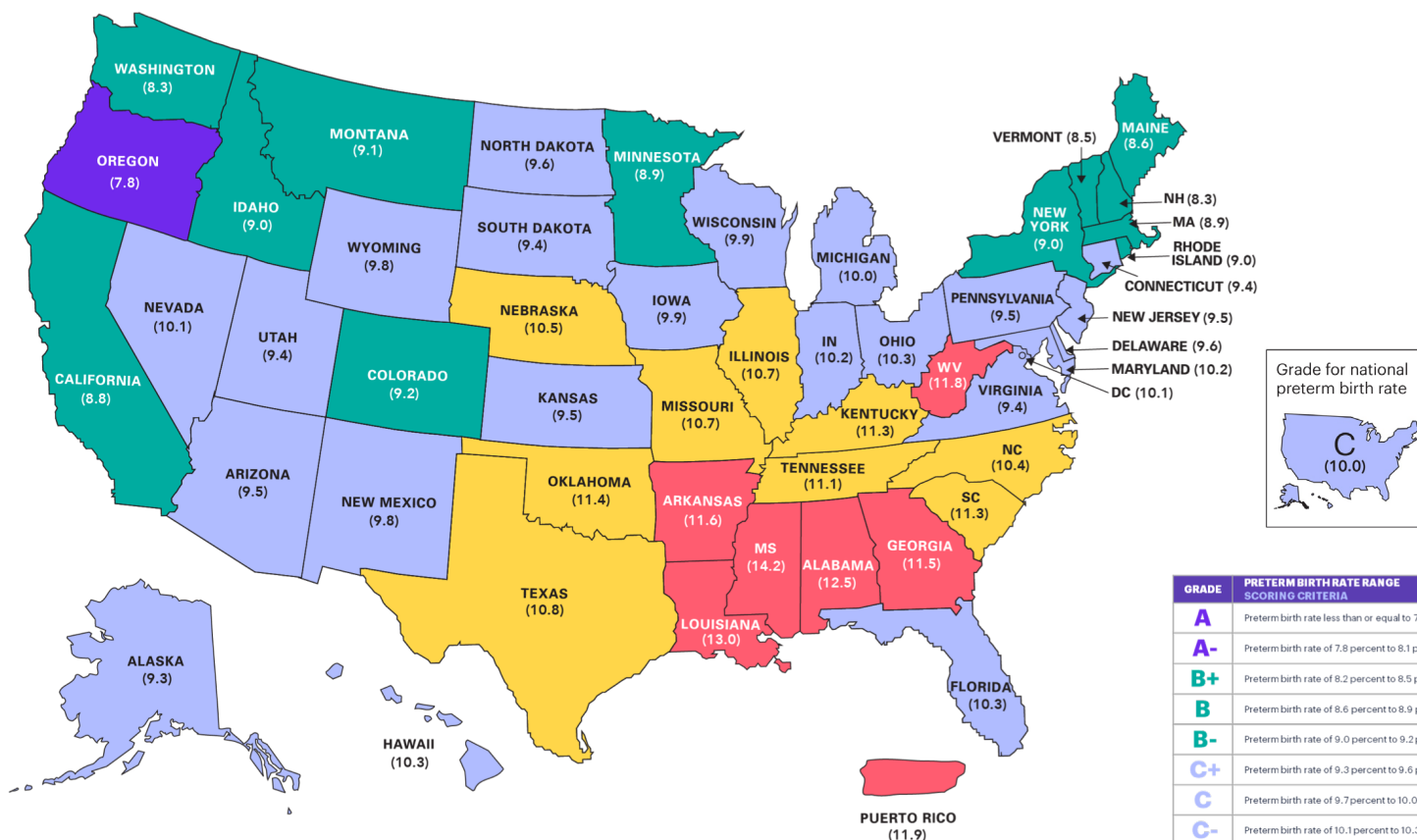
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PRETERM
BIRTH RATE

10.0%

Percentage of live
births born preterm

PRETERM BIRTH RATES AND GRADES BY STATE

Grade for national
preterm birth rate

Puerto Rico is not included in the United States total.

Preterm is less than 37 completed weeks of gestation, based on obstetric estimate of gestational age.

Source: Preterm birth rates are from the National Center for Health Statistics, 2018 final natality data. Grades assigned by March of Dimes Perinatal Data Center.

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MORE INFORMATION

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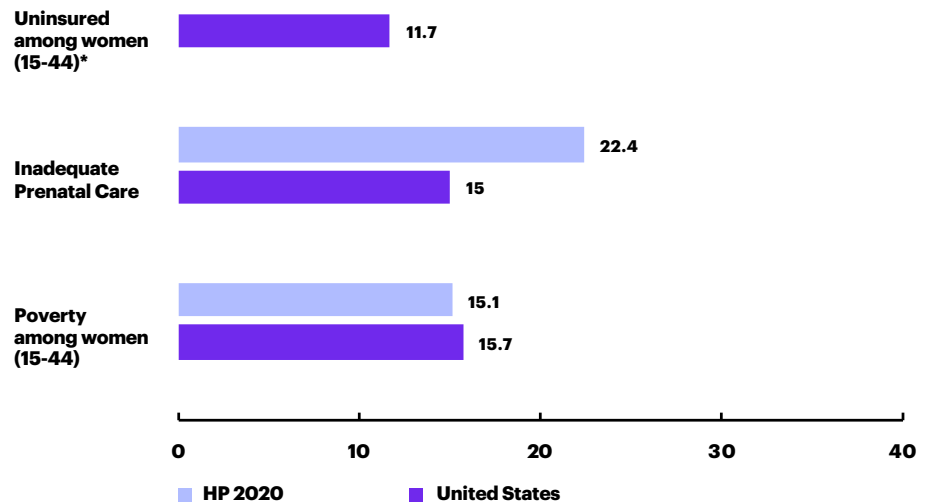
For details on data sources and calculations, see Technical Notes.

For more information on how we are working to reduce premature birth, visit www.marchofdimes.org.

UNITED STATES MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$65 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. Cost estimate reflects 2016 adjustments to underlying estimate developed in 2005 (see technical notes for additional details). Adjustments include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

\$21.1 BILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

The Maternal and Child Health (MCH) Block Grant is one source of federal support for states to improve the health of moms and children. States have some flexibility in allocating funds, which can be used to increase access to quality health care for pregnant women. MCH block grant amounts provide an example of the limited amount of available funds in comparison to the costs of prematurity and other complications.

NOT ADOPTED in 14 STATES

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED ACTIONS

March of Dimes recommends [key policy actions](#) to improve maternal and infant health. Future Report Cards will assess these actions.

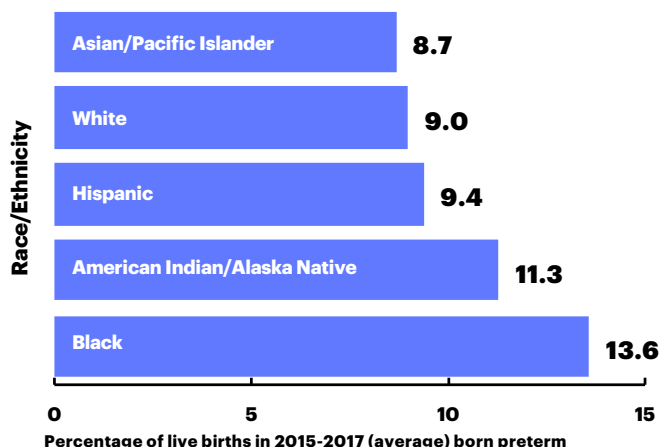
- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

MORE INFORMATION [MARCHOFDIMES.ORG/REPORTCARD](https://www.marchofdimes.org/reportcard)

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2019 MARCH OF DIMES REPORT CARD RACE & ETHNICITY IN THE U.S.

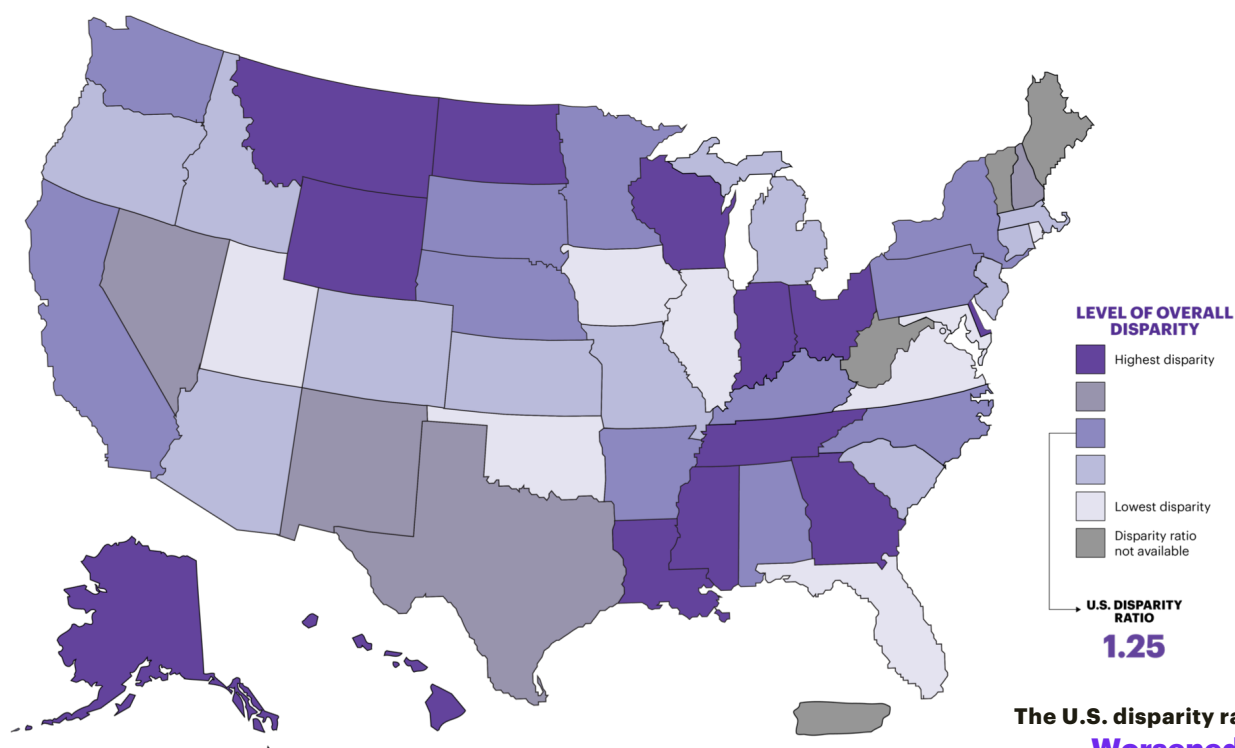
Aggregate 2015-2017 preterm birth rates are shown for each of the five bridged racial and ethnic groups. The racial/ethnic group with the highest rate is compared to the combined rate for all other racial/ethnic groups.



In the United States, the preterm birth rate among black women is 49% higher than the rate among all other women.

RACE & ETHNICITY DISPARITY BY STATE

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It is based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



The U.S. disparity ratio has **Worsened** from baseline

MORE INFORMATION

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2019 MARCH OF DIMES REPORT CARD

TECHNICAL NOTES

PREMATURE BIRTH: DEFINITION AND SOURCE

Premature or preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the National Center for Health Statistics (NCHS) natality files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.¹ This national data source was used so that data are comparable for each state and jurisdiction-specific report card. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to timing of data submission and handling of missing data. The preterm birth rates shown at the top of report card was calculated from the NCHS 2018 final natality data. Preterm birth rates in the trend graph are from the NCHS 2008-2018 final natality data. County preterm birth rates are from the NCHS 2017 final natality data. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2015-2017 final natality data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

GRADING METHODOLOGY

Expanded grade ranges were introduced in 2019. Grade ranges remain based on standard deviations of final 2014 state and District of Columbia preterm birth rates away from the March of Dimes goal of 8.1 percent by 2020. Grades were determined using the following scoring formula: (preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and District of Columbia preterm birth rates. Each score within a grade was divided into thirds to create +/- intervals. The resulting scores were rounded to one decimal place and assigned a grade. See the table for details.

PREMATURE BIRTH BY COUNTY

Report cards for states and jurisdictions, except District of Columbia, display up to 6 counties with the greatest number of live births. Counties are not displayed if the number of premature births is less than 20. Counties are ordered alphabetically. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2017 county preterm birth rate to the 2016 rate.

PREMATURE BIRTH BY CITY

Report cards for states and jurisdictions, except District of Columbia, display the city with the greatest number of live births. Cities are not displayed for Connecticut, Delaware, Maine, Vermont, West Virginia and Wyoming due to limited availability of data. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2017 city preterm birth rate to the 2016 rate.

PREMATURE BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother's race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 20 or more premature births in each year from 2015-2017. To calculate preterm birth rates on the report card, three years of data were aggregated (2015-2017). Preterm birth rates for not stated/unknown race are not shown on the report card.

PREMATURE BIRTH DISPARITY MEASURES

The March of Dimes disparity ratio is based on Healthy People 2020 methodology and provides a measure of the differences, or disparities, in preterm birth rates across racial/ethnic groups within a geographic area.² The disparity ratio compares the racial/ethnic group with the lowest preterm birth rate (comparison group) to the average of the preterm birth rate for all other groups.

To calculate the disparity ratio, the 2015-2017 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2015-2017 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2010-2015) among groups that had 20 or more premature births in each year from 2010-2015. A disparity ratio was calculated for U.S. states, the District of Columbia and the total U.S. A disparity ratio was not calculated for Maine, Puerto Rico, Vermont and West Virginia due to limited availability of data. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Preterm birth rate less than or equal to 7.7 percent
A-	Preterm birth rate of 7.8 percent to 8.1 percent
B+	Preterm birth rate of 8.2 percent to 8.5 percent
B	Preterm birth rate of 8.6 percent to 8.9 percent
B-	Preterm birth rate of 9.0 percent to 9.2 percent
C+	Preterm birth rate of 9.3 percent to 9.6 percent
C	Preterm birth rate of 9.7 percent to 10.0 percent
C-	Preterm birth rate of 10.1 percent to 10.3 percent
D+	Preterm birth rate of 10.4 percent to 10.7 percent
D	Preterm birth rate of 10.8 percent to 11.1 percent
D-	Preterm birth rate of 11.2 percent to 11.4 percent
F	Preterm birth rate greater than or equal to 11.5 percent

2019 MARCH OF DIMES REPORT CARD

TECHNICAL NOTES

PREMATURE BIRTH DISPARITY MEASURES

Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2015-2017 disparity ratio to a baseline (2010-2012) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020.² If the disparity ratio significantly improved because the average preterm birth rate for all other groups got better, we displayed "Improved" on the report card. If the disparity ratio significantly worsened because the lowest group got better or the average of all other groups got worse, we displayed "Worsened" on the report card. If the disparity ratio did not significantly change, we displayed "No Improvement" on the report card.

The report card also provides the percent difference between the racial/ethnic group with the 2015-2017 highest preterm birth rate compared to the combined 2015-2017 preterm birth rate among women in all other racial/ethnic groups. This percent difference was calculated using only the racial/ethnic groups displayed on the state or jurisdiction-specific report card. This difference was calculated for each U.S. state with adequate numbers and the District of Columbia.

SELECTED SOCIAL DETERMINANTS OF HEALTH

March of Dimes recognizes the importance of certain risk factors that are associated with premature birth. Three of these contributing factors are highlighted for each state. These risk factors are poverty in women (age 15-44 years), lack of health insurance in women (15-44 years) and inadequacy of prenatal care.

A woman was considered uninsured if she was not covered by any type of health insurance.³ The uninsured percent is calculated among women ages 15-44. Persons in poverty are defined as those who make less than 100% of the poverty threshold established by the US Census Bureau.⁴ The Federal poverty threshold for a family of three was \$19,749 in 2017. Poverty is reported for women 15-44 years. Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant's gestational age.⁵

FINANCIAL AND ECONOMIC INDICATORS

Estimates of the national societal economic burden of preterm birth in 2005 generated for the Institute of Medicine's (IOM) report⁶, Preterm Birth: Causes, Consequences and Prevention served as the foundation for updating costs to 2016 and for providing separate estimates for each state and the District of Columbia (see https://marchofdimes.org/peristats/documents/Cost_of_Prematurity_2019.pdf for details)⁷. Costs were updated adjusting for price changes over time and for variation in prices of services between states. Changes in the rate of preterm birth, the distribution of preterm birth by gestational age (GA), and the rate of infant mortality by GA at the national and state levels were also incorporated. This cost of preterm birth estimates are the most comprehensive national estimates to date, and provide the first profile of such costs by state for every state and the District of Columbia.

Medicaid expansion is provided as not adopted, adopted and adopted but not implemented. Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.⁸

Maternal and child block grant totals are available from Fiscal Year 2019 for each state. The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is a federal program devoted to improving the health of all women, children and families. Title V provides funding to state maternal and child health (MCH) programs, which serve 76 million people in the U.S.⁹ Maternal and child (MCH) block grants are a key federal source of support for states to improve the health of moms and babies. Other funding sources and strategies are also available to states to make an impact on prematurity.

CALCULATIONS

All natality calculations were conducted by the March of Dimes Perinatal Data Center. Calculations for the cost of premature birth were conducted by the University of Utah.

REFERENCES

¹ National Center for Health Statistics, final natality data 2015-2018.

² Talih M, Huang DT. Measuring progress toward target attainment and the elimination of health disparities in Healthy People 2020. Healthy People Statistical Notes, no 27. Hyattsville, MD: National Center for Health Statistics. 2016.

³ IPUMS-USA, University of Minnesota, ipums.org. American Community Survey, US Census Bureau.

⁴ PUMS-CPS, University of Minnesota, ipums.org. Current Population Survey, US Census Bureau.

⁵ Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994; 84: 1414-1420.

⁶ Behrman RE, Stith Butler A, eds. Institute of Medicine, Committee on Understanding Preterm Birth and Assuring Healthy Outcomes. Preterm Birth: Causes, Consequences, and Prevention. Washington, DC: The National Academies Press; 2007.

⁷ Waitzman NJ and Jalali A. Updating National Preterm Birth Costs to 2016 with Separate Estimates for Individual States. Salt Lake City, UT: University of Utah; 2019.

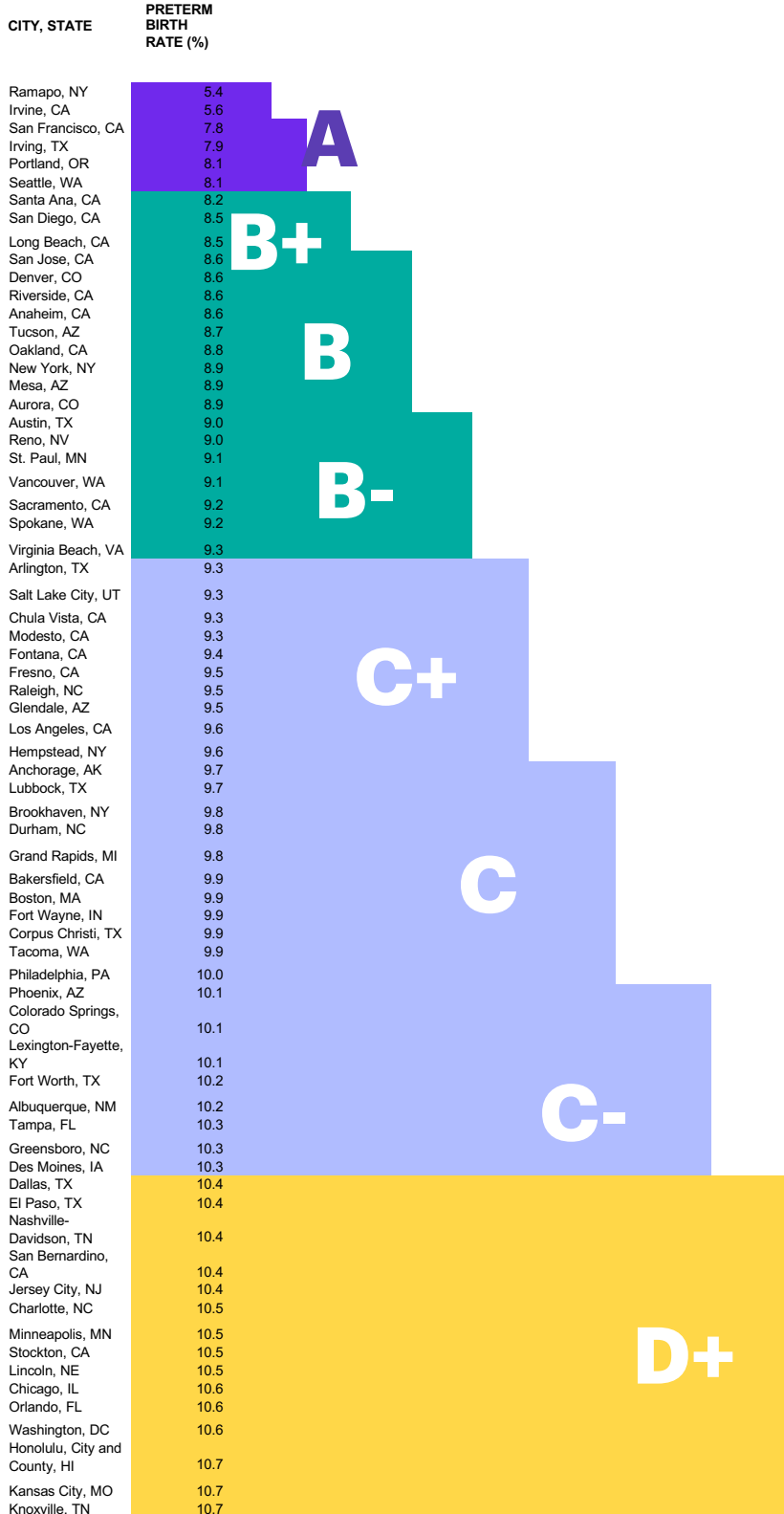
⁸ Kaiser Family Foundation, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>. Retrieved on June 30, 2019.

⁹ Health Resources and Services Administration. Title V Maternal and Child Block Grant Program. Available at: <https://mchb.hrsa.gov/data-research-epidemiology>. Retrieved on September 12, 2019.

100 U.S. CITIES WITH THE GREATEST NUMBER OF BIRTHS 2017 PRETERM BIRTH RATES AND GRADES

March of Dimes 2020 Goal: 8.1 percent

The 2019 U.S. March of Dimes Report Card assigns grades to the 100 cities with the greatest number of live births in 2017. Premature Birth Report Card grades are assigned by comparing the 2017 preterm birth rate in a city to the March of Dimes goal of 8.1 percent by 2020.



GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Preterm birth rate less than or equal to 7.7 percent
A-	Preterm birth rate of 7.8 percent to 8.1 percent
B+	Preterm birth rate of 8.2 percent to 8.5 percent
B	Preterm birth rate of 8.6 percent to 8.9 percent
B-	Preterm birth rate of 9.0 percent to 9.2 percent
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D-	Preterm birth rate of 11.2 percent to 11.4 percent
F	Preterm birth rate greater than or equal to 11.5 percent

100 U.S. CITIES WITH THE GREATEST NUMBER OF BIRTHS

2017 PRETERM BIRTH RATES AND GRADES

CITY, STATE	PRETERM BIRTH RATE (%)	
Miami, FL	10.8	D
Louisville, KY	10.8	
Columbus, OH	10.9	
Islip, NY	10.9	
Las Vegas, NV	11.1	
Laredo, TX	11.1	
Houston, TX	11.2	
Omaha, NE	11.2	
Indianapolis, IN	11.3	
Tulsa, OK	11.4	
Fayetteville, NC	11.4	D-
Wichita, KS	11.5	
Norfolk, VA	11.6	
Jacksonville, FL	11.7	
Cincinnati, OH	11.7	
San Antonio, TX	11.8	
Atlanta, GA	11.9	
Buffalo, NY	11.9	
Oklahoma City, OK	12.2	F
Newark, NJ	12.2	
Toledo, OH	12.3	
Brownsville, TX	12.6	
Milwaukee, WI	12.8	
Birmingham, AL	12.9	
Memphis, TN	13.1	
Baton Rouge, LA	13.1	
Baltimore, MD	13.2	
New Orleans, LA	13.5	
St. Louis, MO	13.7	
Detroit, MI	14.3	
Cleveland, OH	14.5	

Notes:

- Preterm is less than 37 weeks gestation based on obstetric estimate of gestational age.
- Cities represent those with the greatest number of live births out of all cities with a population of >100,000, as defined by the National Center for Health Statistics.
- Cities are sorted by preterm birth rates and alphabetically by city name for cities with the same preterm birth rate.
- *Data for Honolulu represent the combined city and county of Honolulu. Data are not comparable to past years.
- See the U.S. 2019 March of Dimes Report Card for more information.

Source: National Center for Health Statistics, 2017 final natality data.

Prepared by: March of Dimes Perinatal Data Center, 2019.

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REPORT CARD

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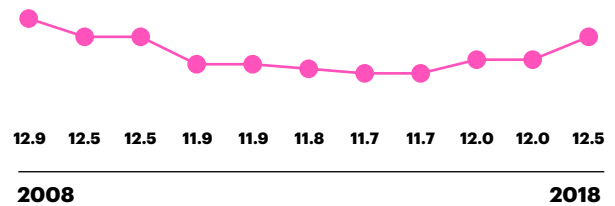
ALABAMA

PREMATURITY
GRADE

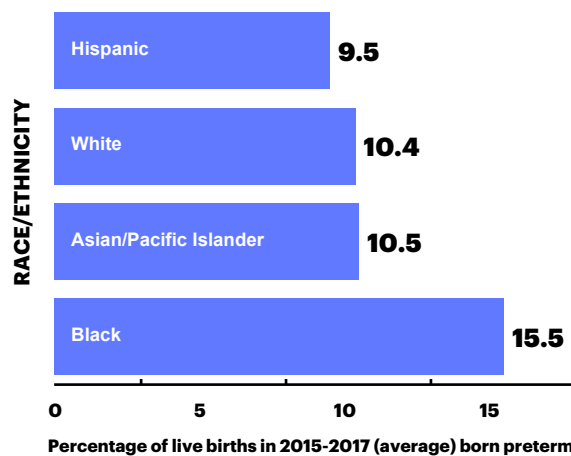
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PRETERM
BIRTH RATE

12.5%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Alabama, the preterm birth rate among black women is 50% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baldwin	C	9.9%	Worsened
Jefferson	F	11.9%	Improved
Madison	F	12.3%	Improved
Mobile	F	13.8%	Improved
Montgomery	F	12.8%	Improved
Tuscaloosa	F	12.8%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Birmingham	F	12.9%	Worsened

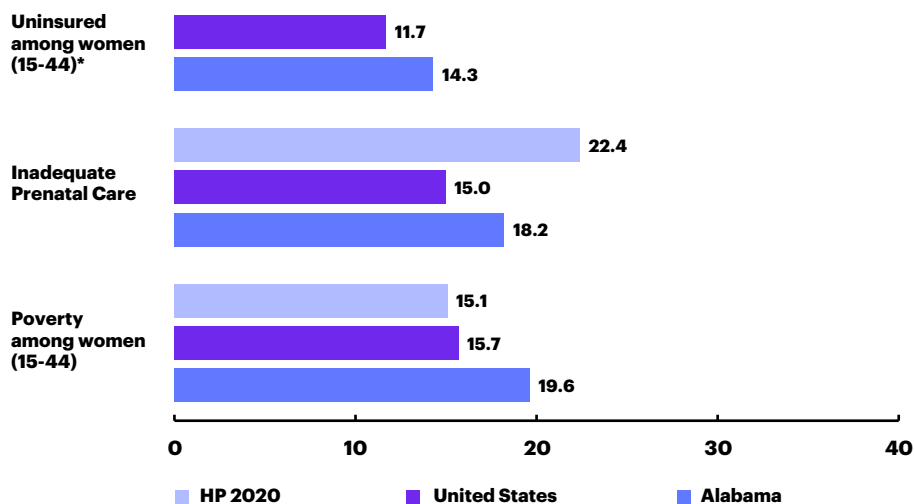
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*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$60 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$11.40 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

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- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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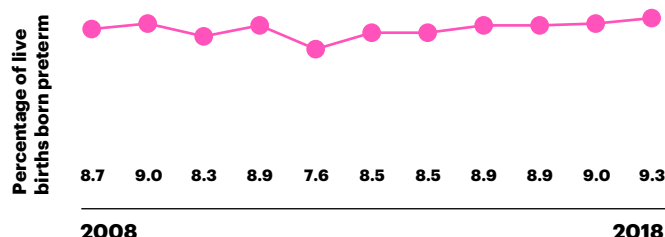
ALASKA

PREMATURITY
GRADE

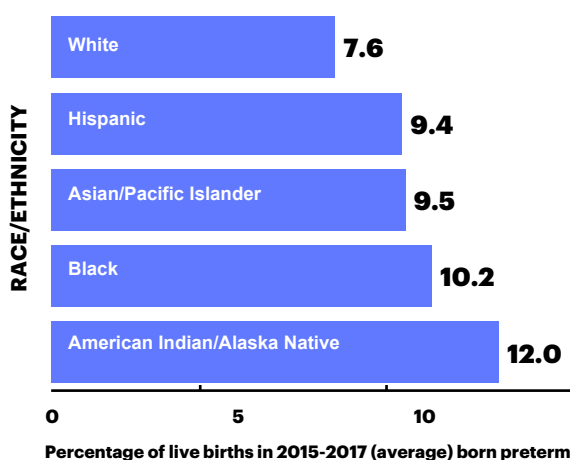
C+

PRETERM
BIRTH RATE

9.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Alaska, the preterm birth rate among American Indian/Alaska Native women is 48% higher than the rate among all other women.

DISPARITY RATIO:

1.36

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY BOROUGH AND CITY

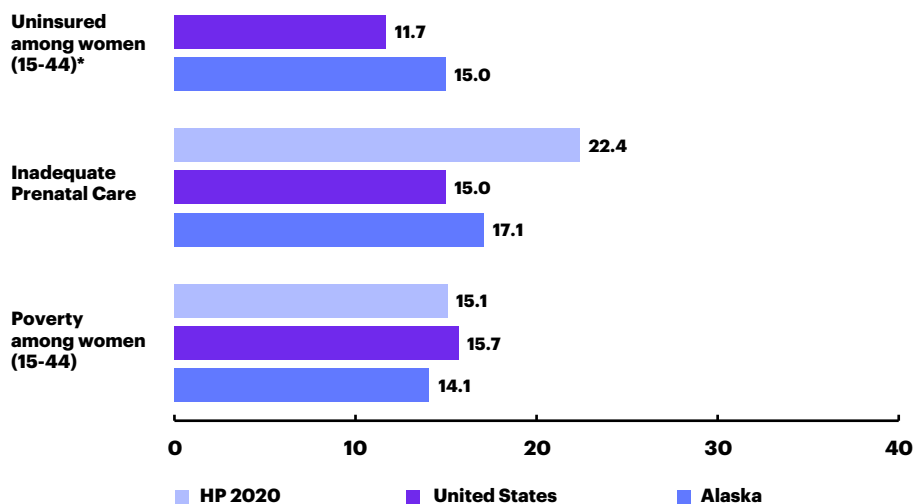
BOROUGH	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Anchorage	C	9.7%	Worsened
Bethel (Census Area)	D+	10.7%	Improved
Fairbanks North Star	A-	7.8%	Improved
Juneau	B+	8.2%	Worsened
Kenai Peninsula	A	7.5%	Improved
Matanuska-Susitna	A-	8.1%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Anchorage	C	9.7%	Worsened

ALASKA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$66 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$1.08 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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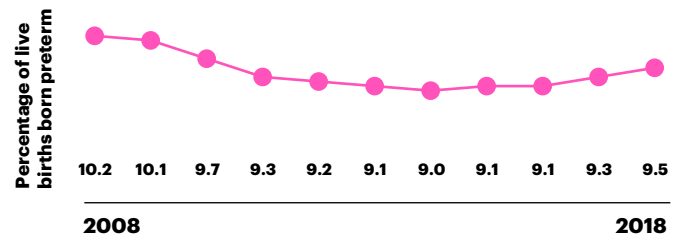
ARIZONA

PREMATURITY
GRADE

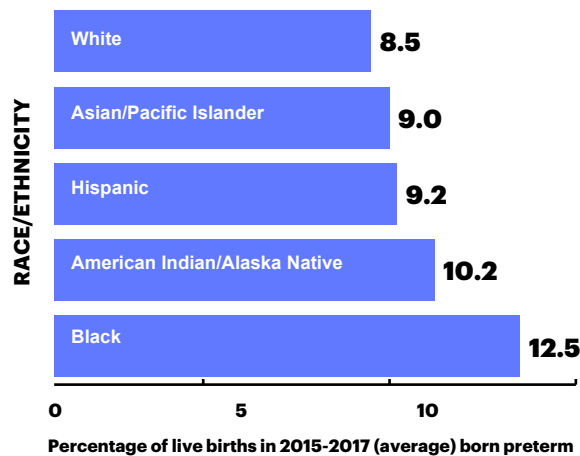
C+

PRETERM
BIRTH RATE

9.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Arizona, the preterm birth rate among black women is 40% higher than the rate among all other women.

DISPARITY RATIO:

1.21

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Maricopa	C+	9.4%	Worsened
Mohave	B	8.6%	Worsened
Pima	B+	8.5%	Worsened
Pinal	C+	9.6%	Worsened
Yavapai	B+	8.3%	Improved
Yuma	B+	8.3%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Phoenix	C-	10.1%	Worsened

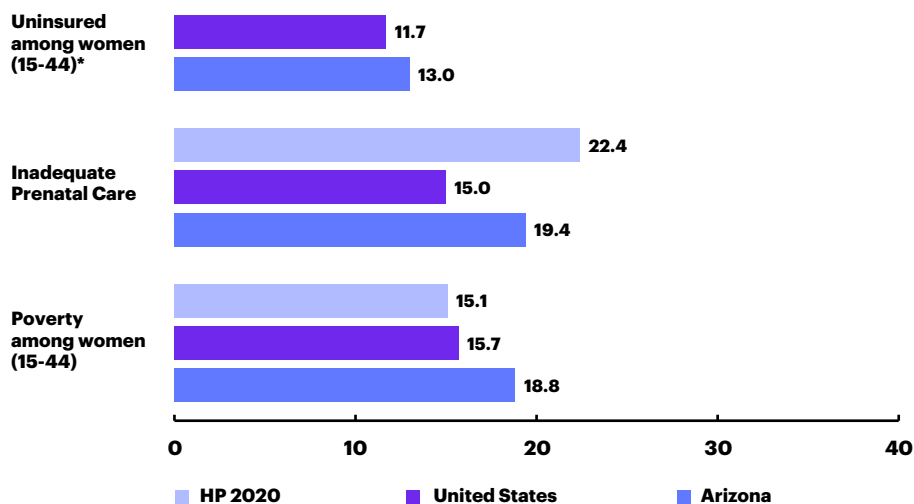
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ARIZONA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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\$61 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$7.39 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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ARKANSAS

PREMATURITY
GRADE

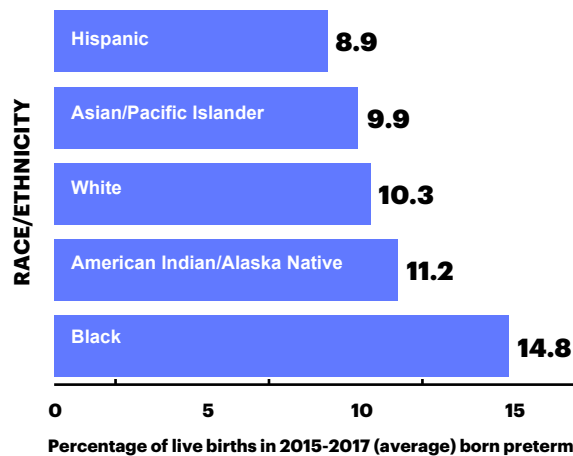
F

PRETERM
BIRTH RATE

11.6%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Arkansas, the preterm birth rate among black women is 47% higher than the rate among all other women.

DISPARITY RATIO:

1.29

CHANGE FROM BASELINE:

No Improvement

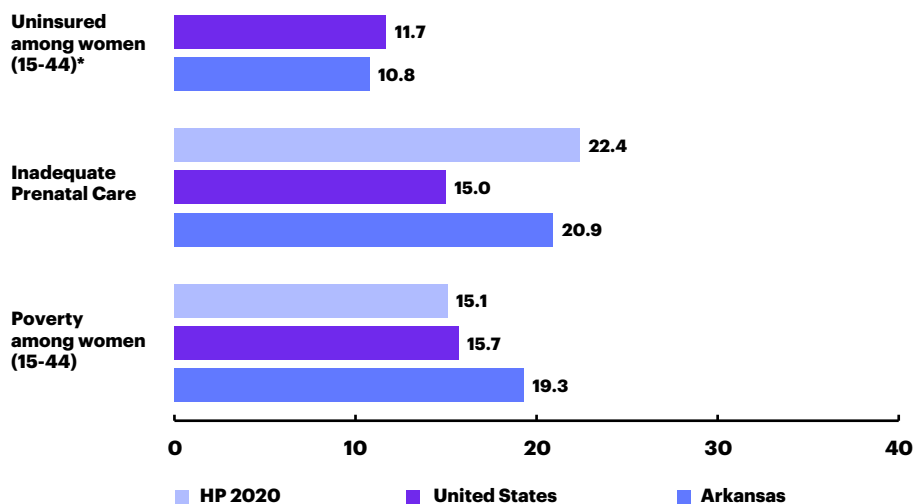
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Benton	C-	10.2%	Worsened
Craighead	F	12.3%	Worsened
Faulkner	D-	11.2%	Worsened
Pulaski	F	11.5%	Improved
Sebastian	F	11.9%	Worsened
Washington	C	9.8%	Improved

ARKANSAS MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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**\$59
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$6.97
MILLION**

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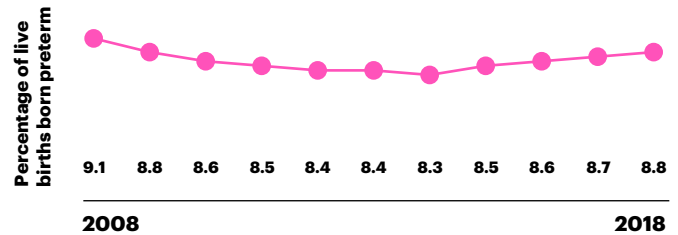
CALIFORNIA

PREMATURITY
GRADE

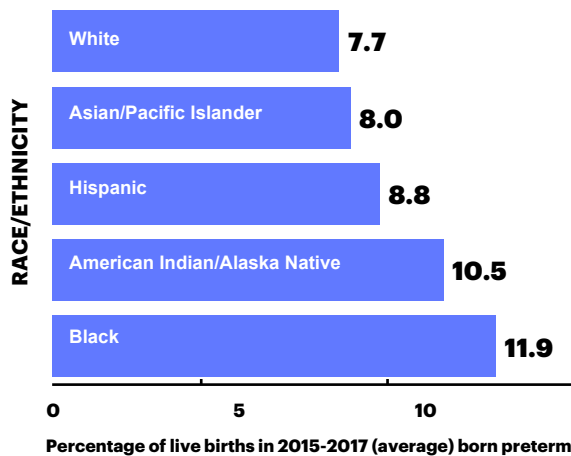
B

PRETERM
BIRTH RATE

8.8%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In California, the preterm birth rate among black women is 43% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

Worsened

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Los Angeles	B-	9.0%	No change
Orange	A	7.5%	Improved
Riverside	B	8.8%	Worsened
San Bernardino	C+	9.3%	No change
San Diego	B+	8.4%	Improved
Santa Clara	B+	8.4%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Los Angeles	C+	9.6%	Worsened

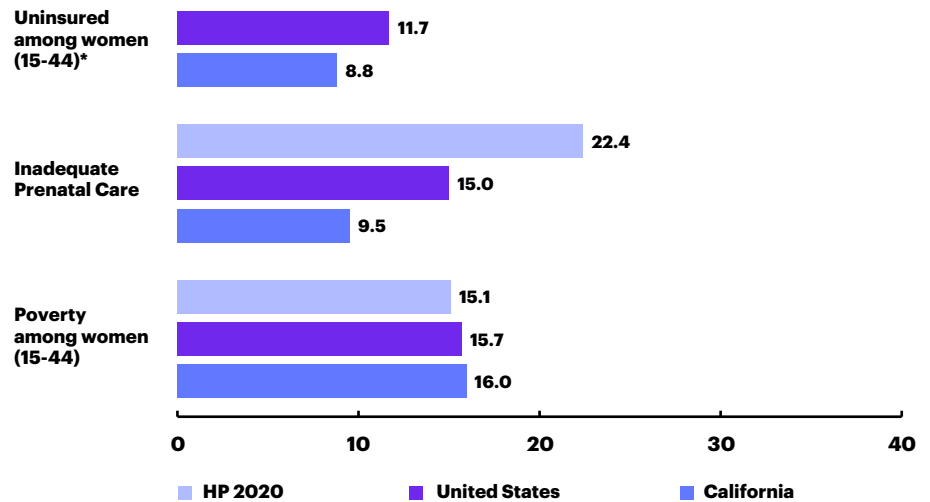
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CALIFORNIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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**\$75
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$39.66
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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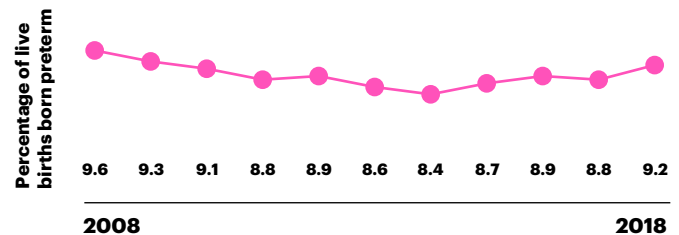
COLORADO

PREMATURITY
GRADE

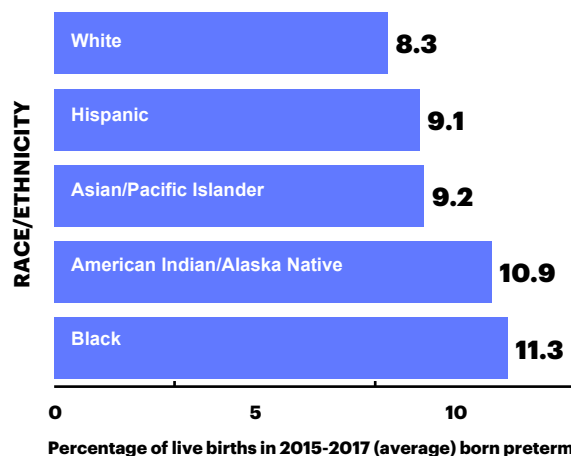
B-

PRETERM
BIRTH RATE

9.2%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Colorado, the preterm birth rate among black women is 31% higher than the rate among all other women.

DISPARITY RATIO:

1.23

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Adams	B+	8.4%	Improved
Arapahoe	B	8.9%	Improved
Denver	B	8.6%	Improved
El Paso	C	9.8%	Worsened
Jefferson	A	7.0%	Improved
Weld	A-	8.1%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Denver	B	8.6%	Improved

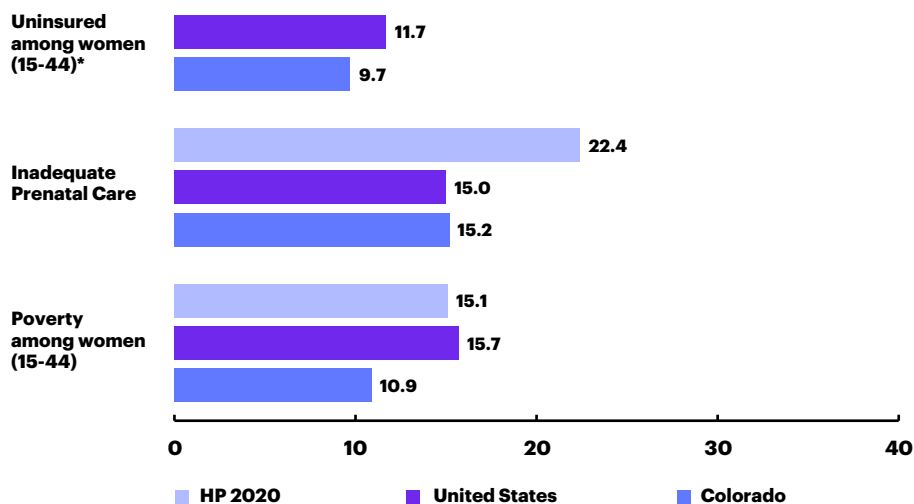
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COLORADO MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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\$60 THOUSAND

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ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

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2019
MARCH OF DIMES
REPORT CARD

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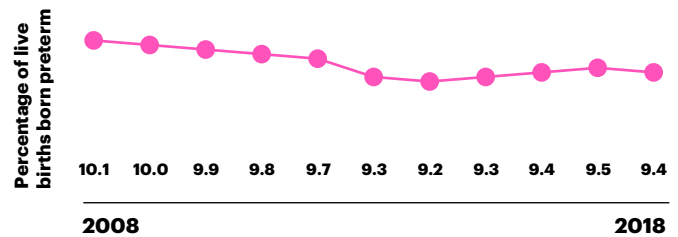
CONNECTICUT

PREMATURITY
GRADE

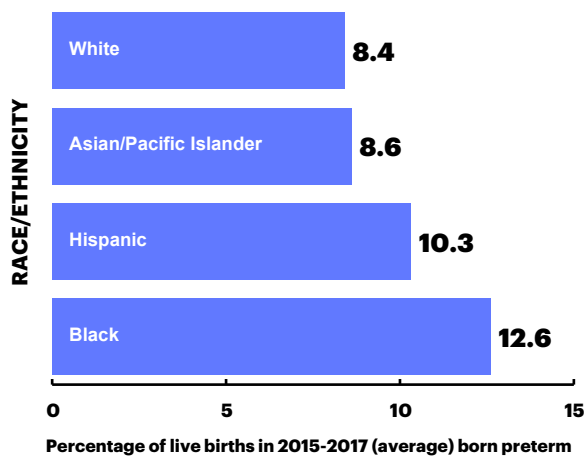
C+

PRETERM
BIRTH RATE

9.4%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Connecticut, the preterm birth rate among black women is 42% higher than the rate among all other women.

DISPARITY RATIO:

1.22

CHANGE FROM BASELINE:

No Improvement

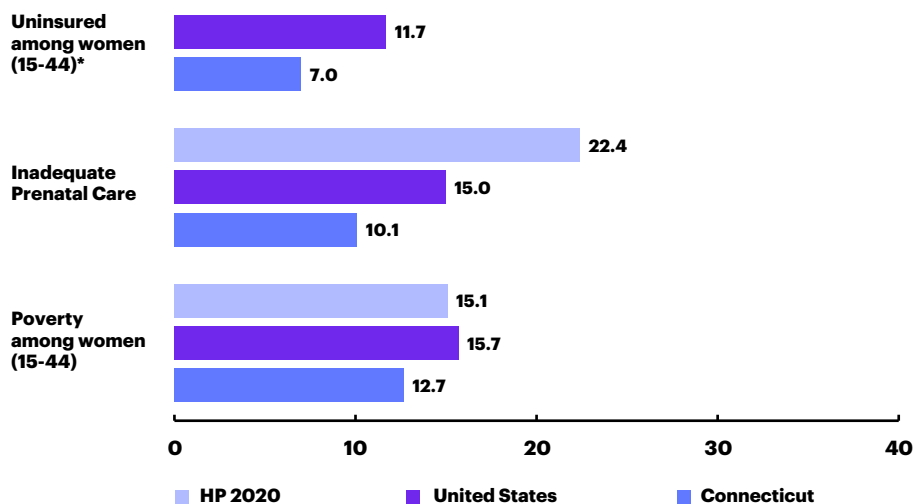
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Fairfield	C+	9.4%	Worsened
Hartford	D+	10.4%	Improved
Litchfield	A-	8.1%	Worsened
Middlesex	A	7.5%	No change
New Haven	C	9.8%	Worsened
New London	A	7.6%	Improved

CONNECTICUT MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$72
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$4.67
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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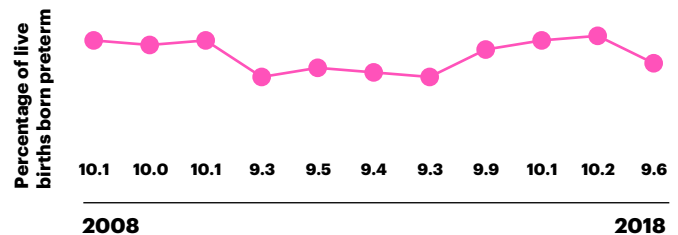
DELAWARE

PREMATURITY
GRADE

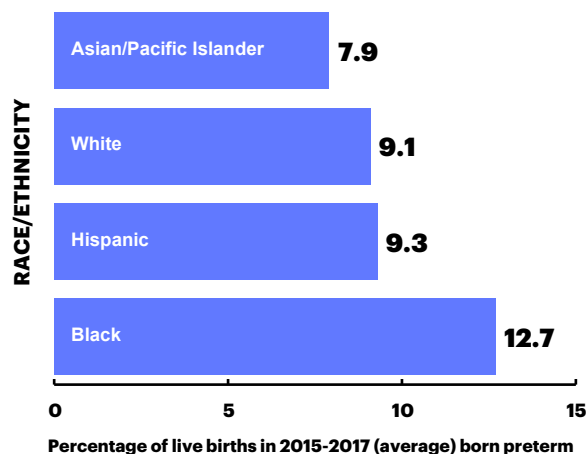
C+

PRETERM
BIRTH RATE

9.6%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Delaware, the preterm birth rate among black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

No Improvement

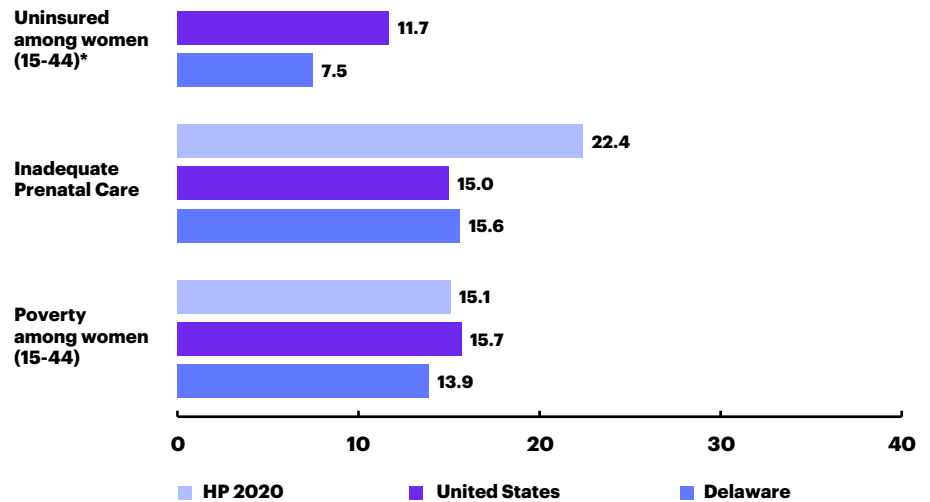
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Kent	D	10.9%	Worsened
New Castle	C	10.0%	Improved
Sussex	C-	10.1%	Worsened

DELAWARE MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$74
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$1.99
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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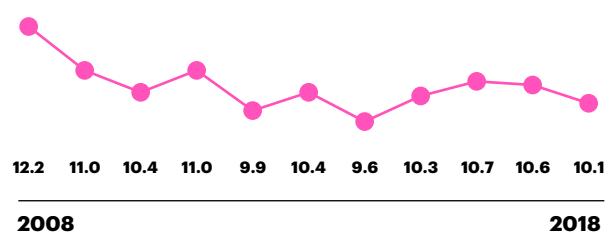
DISTRICT OF COLUMBIA

PREMATURITY
GRADE

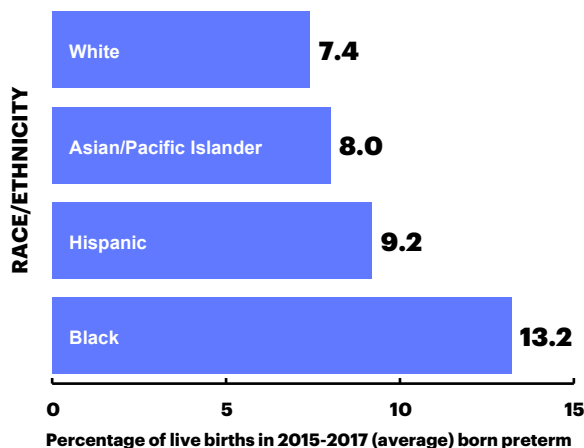
C-

PRETERM
BIRTH RATE

10.1%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In District of Columbia, the preterm birth rate among black women is 65% higher than the rate among all other women.

DISPARITY RATIO:

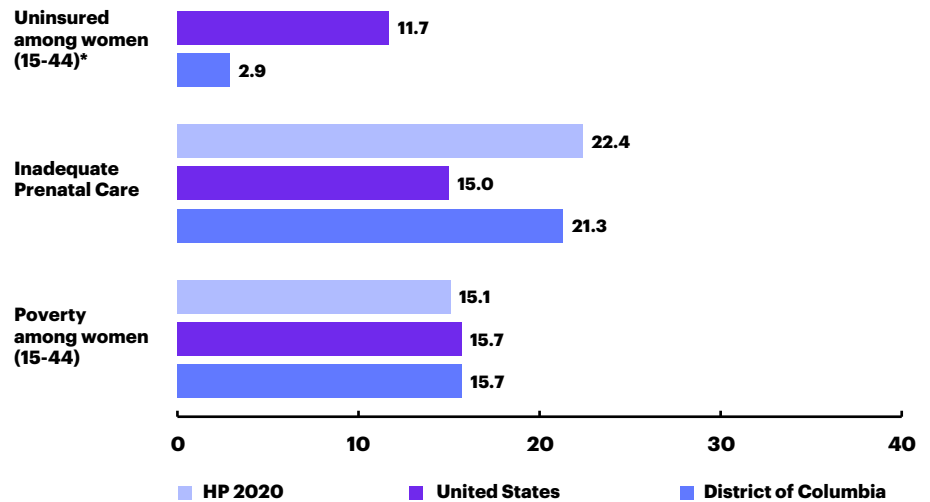
1.25

CHANGE FROM BASELINE:
No Improvement

DISTRICT OF COLUMBIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$75
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$6.91
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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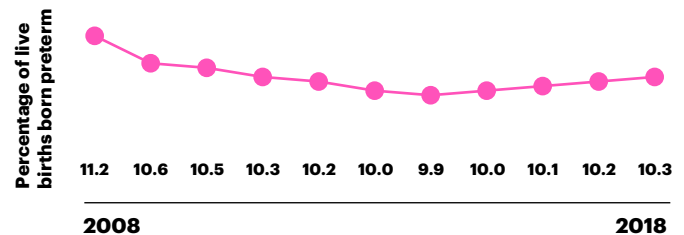
FLORIDA

PREMATURITY
GRADE

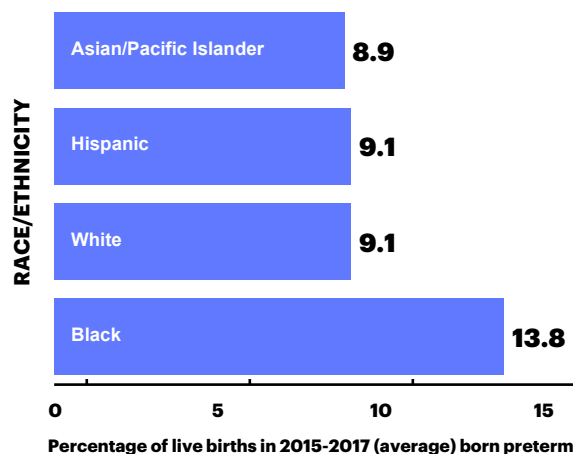
C-

PRETERM
BIRTH RATE

10.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Florida, the preterm birth rate among black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Broward	D	10.8%	Improved
Duval	F	11.7%	Worsened
Hillsborough	C-	10.1%	Worsened
Miami-Dade	C	9.8%	No change
Orange	C-	10.3%	Worsened
Palm Beach	C+	9.4%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jacksonville	F	11.7%	Worsened

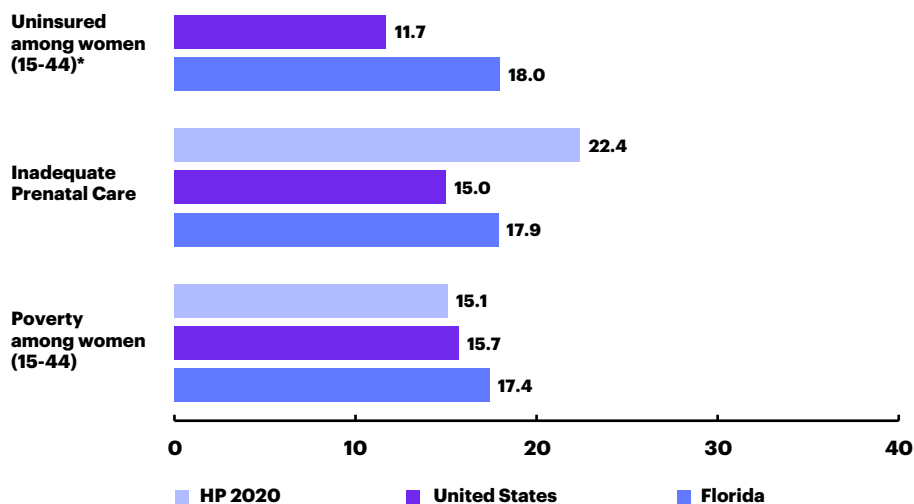
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FLORIDA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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\$65 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$19.44 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

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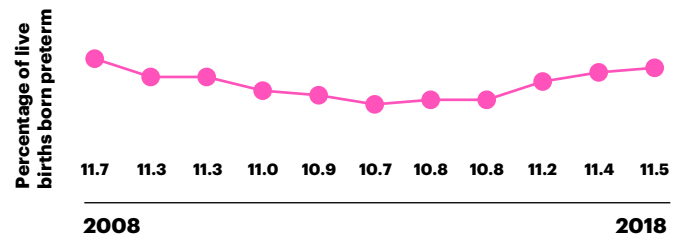
GEORGIA

PREMATURITY
GRADE

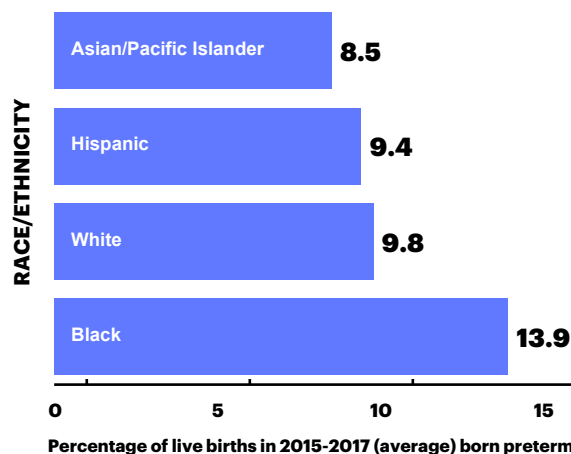
F

PRETERM
BIRTH RATE

11.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Georgia, the preterm birth rate among black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chatham	F	11.7%	No change
Clayton	F	12.7%	Worsened
Cobb	D+	10.7%	Worsened
DeKalb	D+	10.6%	Improved
Fulton	D-	11.4%	Worsened
Gwinnett	C-	10.1%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Atlanta	F	11.9%	Worsened

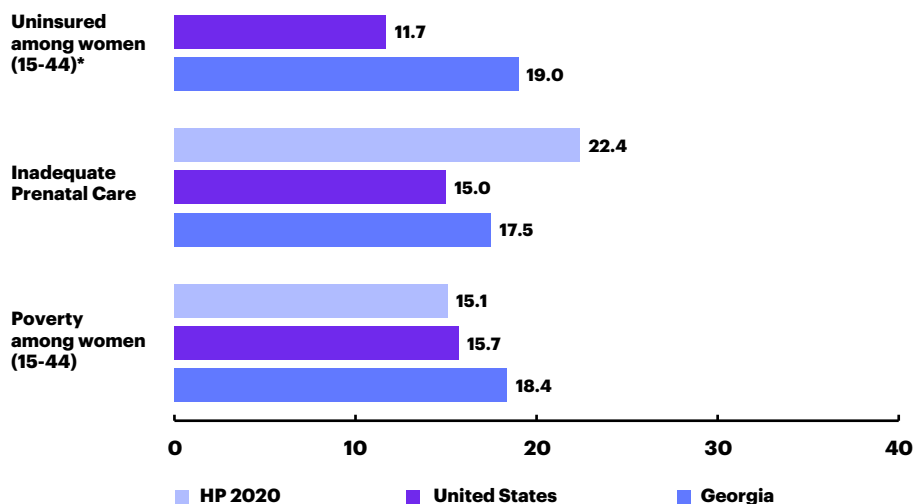
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GEORGIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$17.13
MILLION**

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NOT ADOPTED

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This year, in addition to monitoring progress on key indicators, Report Cards include selected state actions to improve maternal and infant health. Premature birth and its complications are the largest contributors to infant death in the U.S., and preterm birth rates have been increasing for four years. Prematurity grades are assigned by comparing the 2018 preterm birth rate to March of Dimes' goal of 8.1 percent by 2020. While it's not yet possible to assign grades for maternal health indicators given the available data, it's clear that rates of maternal death and morbidity are unacceptably high. Maternal health complications, and the social determinants of health, affect the health and survival of both mom and baby. Highlighted on the second page are selected actions available to states to help improve maternal and infant health.

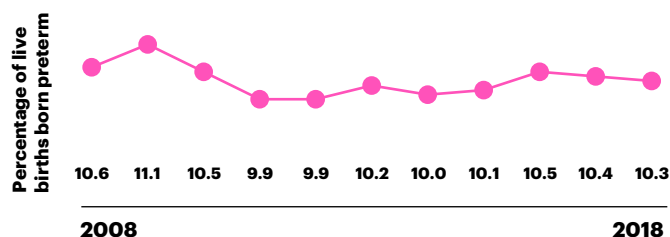
HAWAII

PREMATURITY
GRADE

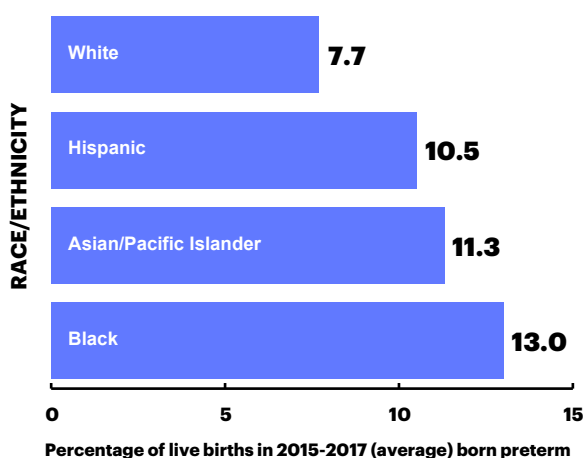
C-

PRETERM
BIRTH RATE

10.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Hawaii, the preterm birth rate among black women is 27% higher than the rate among all other women.

DISPARITY RATIO:

1.50

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Hawaii	D+	10.5%	Improved
Honolulu	D+	10.7%	Worsened
Kauai	C-	10.1%	Worsened
Maui	B-	9.1%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Honolulu, City and County	D+	10.7%	Worsened

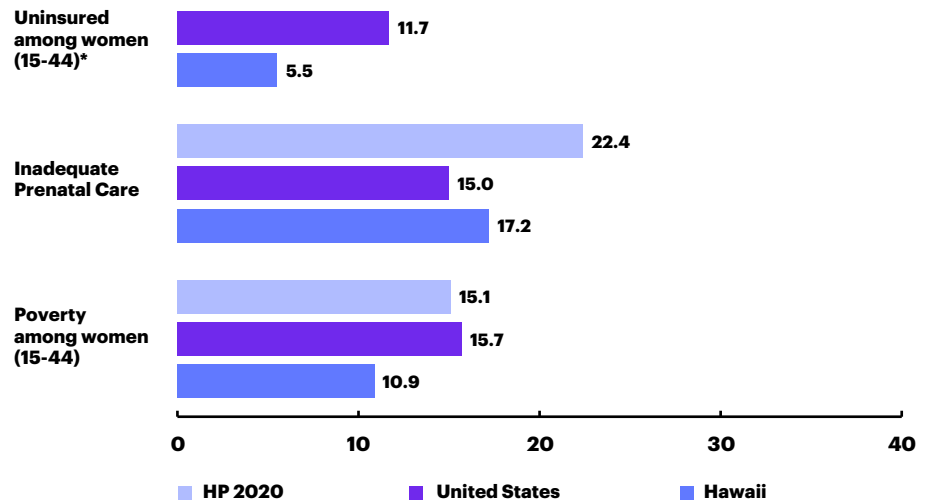
MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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HAWAII MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$73 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$2.11 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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2019
MARCH OF DIMES
REPORT CARD

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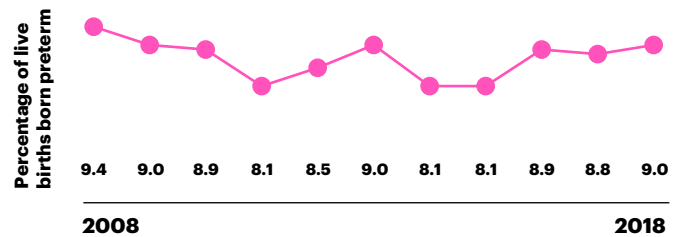
IDAHO

PREMATURITY
GRADE

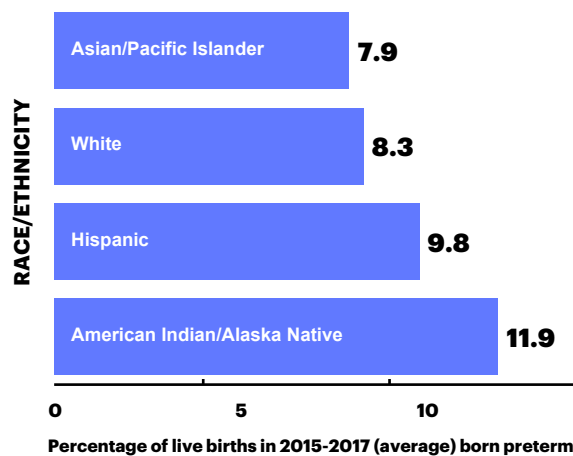
B-

PRETERM
BIRTH RATE

9.0%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Idaho, the preterm birth rate among American Indian/Alaska Native women is 40% higher than the rate among all other women.

DISPARITY RATIO:

1.18

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Ada	A-	8.0%	Improved
Bannock	D+	10.6%	Worsened
Bonneville	D+	10.4%	Worsened
Canyon	C-	10.2%	Worsened
Kootenai	A	7.7%	Worsened
Twin Falls	B-	9.0%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Boise City	A-	8.0%	Worsened

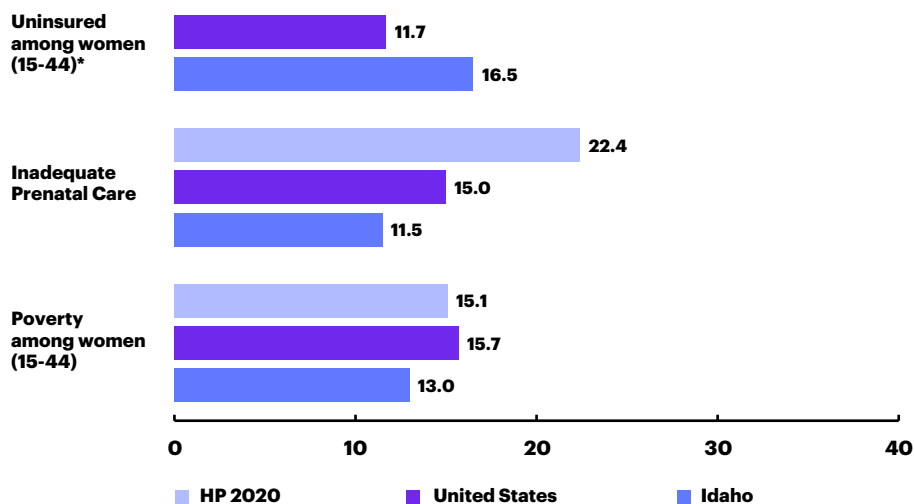
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IDAHO MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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\$55 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$3.27 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED BUT NOT IMPLEMENTED

MEDICAID EXPANSION

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2019
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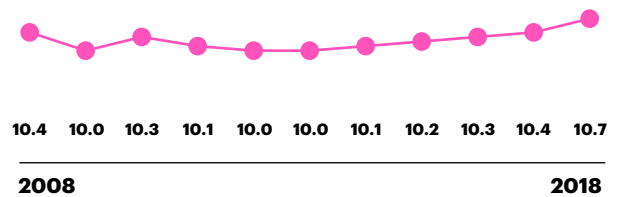
ILLINOIS

PREMATURITY
GRADE

D+

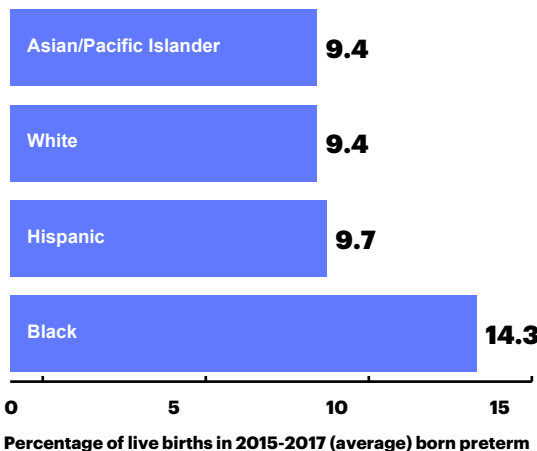
PRETERM
BIRTH RATE

10.7%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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RACE/ETHNICITY



In Illinois, the preterm birth rate among black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.14

CHANGE FROM BASELINE:
Improved

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cook	D+	10.4%	Improved
DuPage	C+	9.4%	Worsened
Kane	C-	10.1%	Improved
Lake	C-	10.2%	Worsened
Will	C-	10.3%	Improved
Winnebago	D-	11.2%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chicago	D+	10.6%	Improved

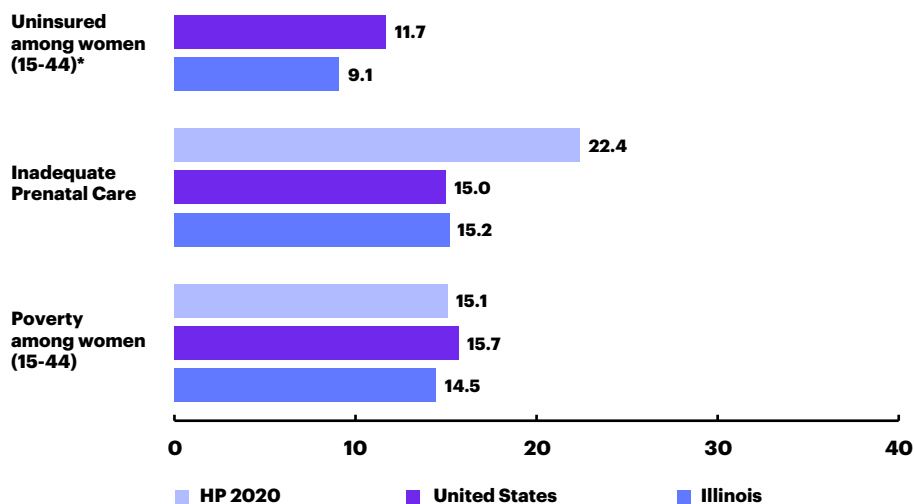
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ILLINOIS MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$67 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$21.10 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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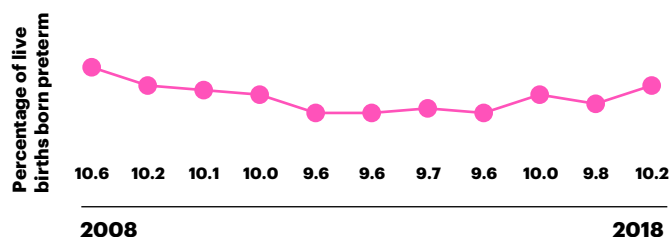
INDIANA

PREMATURITY
GRADE

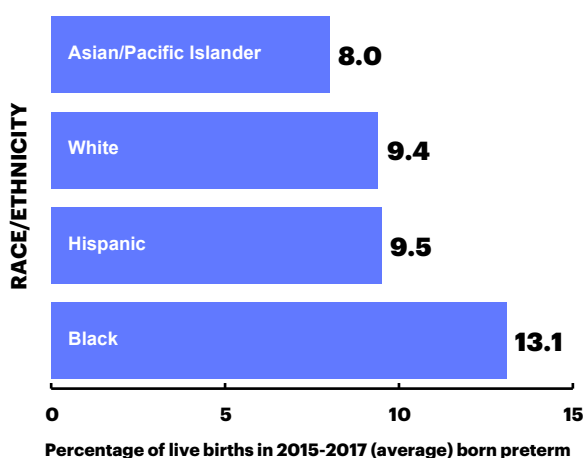
C-

PRETERM
BIRTH RATE

10.2%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Indiana, the preterm birth rate among black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.33

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Allen	C+	9.6%	Worsened
Elkhart	B-	9.2%	Improved
Hamilton	B	8.9%	Improved
Lake	C+	9.4%	Improved
Marion	D-	11.3%	Improved
St. Joseph	D+	10.5%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Indianapolis	D-	11.3%	Improved

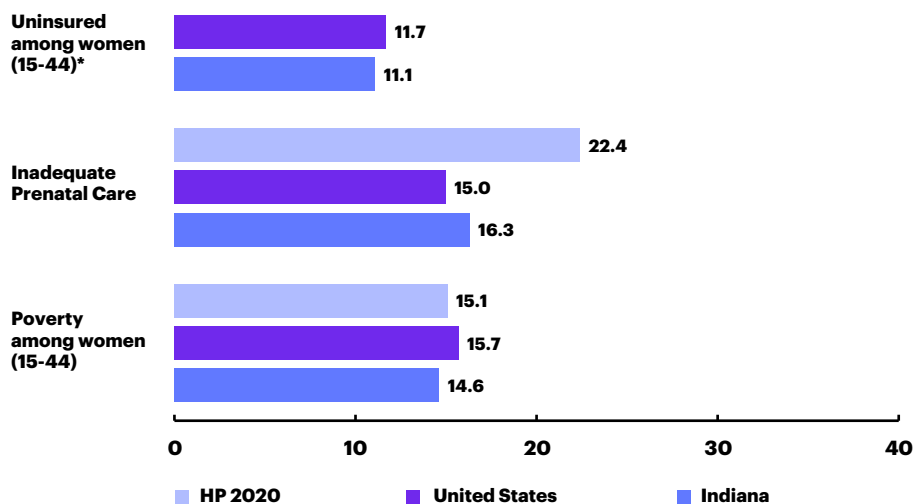
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INDIANA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$63
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$12.27
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

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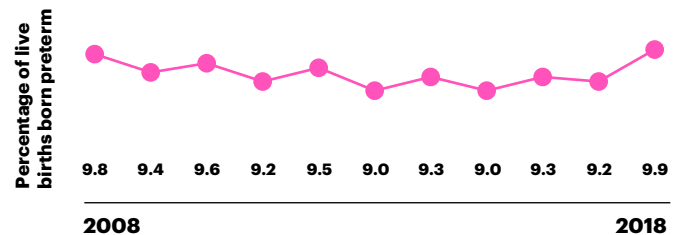
IOWA

PREMATURITY
GRADE

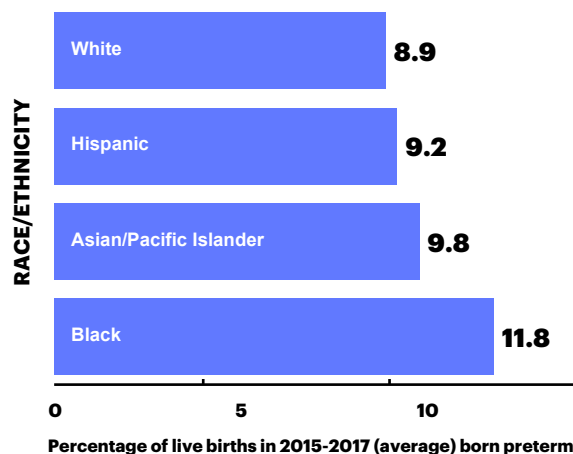
C

PRETERM
BIRTH RATE

9.9%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Iowa, the preterm birth rate among black women is 33% higher than the rate among all other women.

DISPARITY RATIO:

1.11

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Black Hawk	C+	9.5%	Worsened
Johnson	B+	8.3%	Improved
Linn	B	8.8%	Worsened
Polk	B-	9.1%	Improved
Scott	C-	10.3%	Worsened
Woodbury	C	10.0%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Des Moines	C-	10.3%	Same

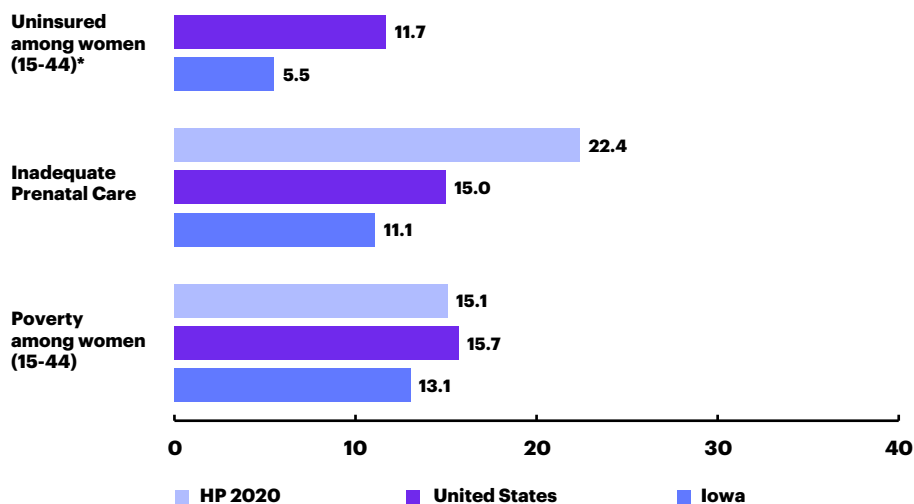
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IOWA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$58
THOUSAND**

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**\$6.51
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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REPORT CARD

This year, in addition to monitoring progress on key indicators, Report Cards include selected state actions to improve maternal and infant health. Premature birth and its complications are the largest contributors to infant death in the U.S., and preterm birth rates have been increasing for four years. Prematurity grades are assigned by comparing the 2018 preterm birth rate to March of Dimes' goal of 8.1 percent by 2020. While it's not yet possible to assign grades for maternal health indicators given the available data, it's clear that rates of maternal death and morbidity are unacceptably high. Maternal health complications, and the social determinants of health, affect the health and survival of both mom and baby. Highlighted on the second page are selected actions available to states to help improve maternal and infant health.

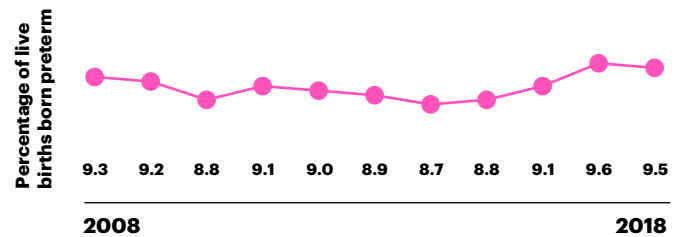
KANSAS

PREMATURITY
GRADE

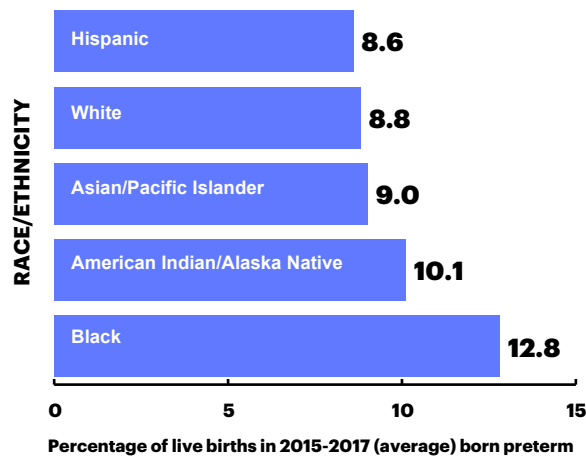
C+

PRETERM
BIRTH RATE

9.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Kansas, the preterm birth rate among black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Douglas	D+	10.4%	Worsened
Johnson	B-	9.0%	Worsened
Leavenworth	B+	8.3%	Improved
Sedgwick	D-	11.3%	Worsened
Shawnee	D	10.8%	Worsened
Wyandotte	D+	10.7%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Wichita	F	11.5%	Worsened

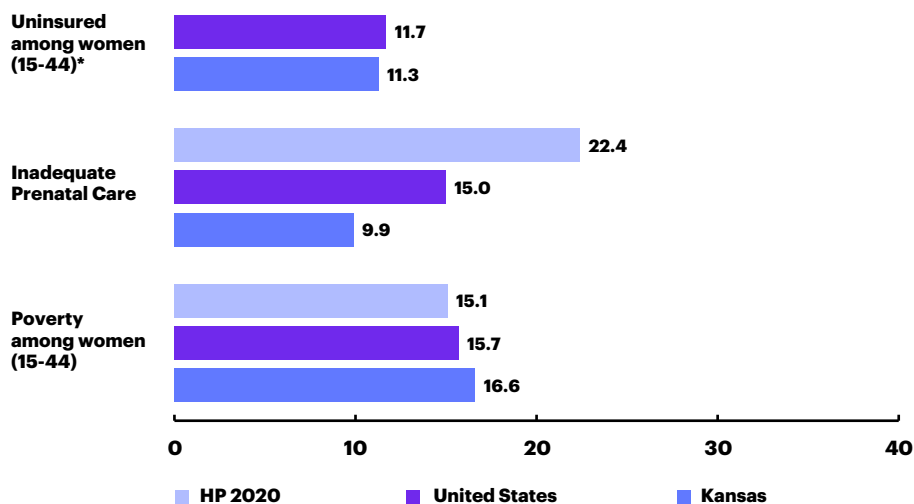
MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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KANSAS MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$56
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$4.77
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

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- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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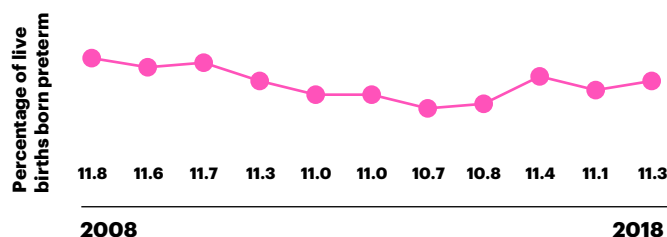
KENTUCKY

PREMATURITY
GRADE

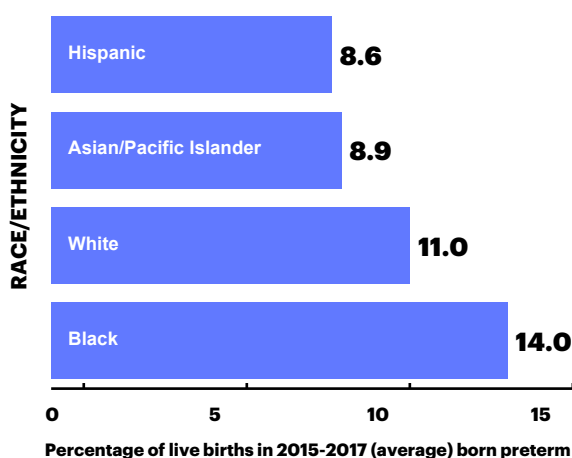
D-

PRETERM
BIRTH RATE

11.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Kentucky, the preterm birth rate among black women is 30% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Boone	B-	9.0%	Improved
Fayette	C-	10.1%	Improved
Hardin	D	11.1%	Worsened
Jefferson	D	10.8%	Improved
Kenton	F	11.8%	Improved
Warren	C	9.7%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Louisville	D	10.8%	Improved

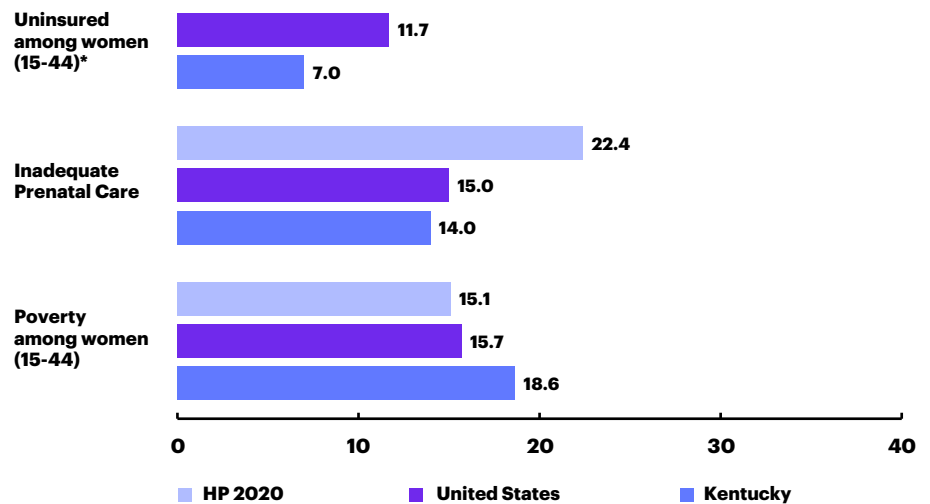
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KENTUCKY MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$58
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$11.09
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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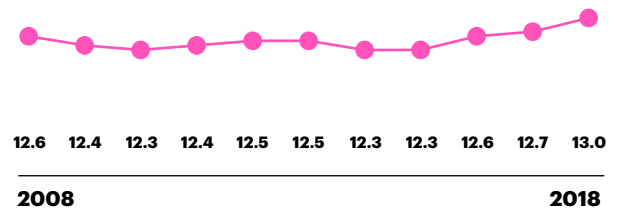
LOUISIANA

PREMATURITY
GRADE

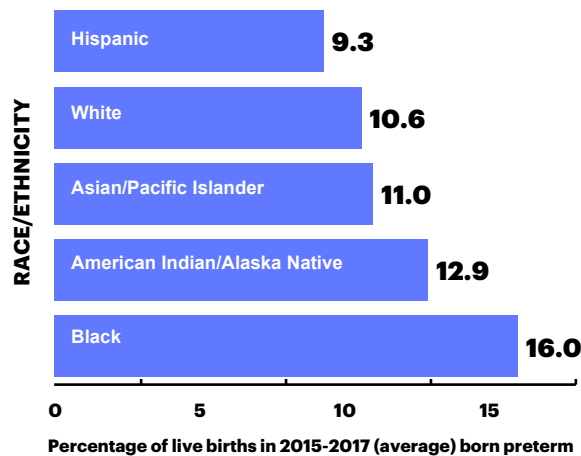
F

PRETERM
BIRTH RATE

13.0%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Louisiana, the preterm birth rate among black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.35

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY PARISHES AND CITY

PARISH	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Caddo	F	18.1%	Worsened
Calcasieu	F	13.5%	Worsened
East Baton Rouge	F	12.7%	Improved
Jefferson	D+	10.7%	Improved
Lafayette	D+	10.6%	Improved
Orleans	F	13.5%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baton Rouge	F	13.1%	Improved

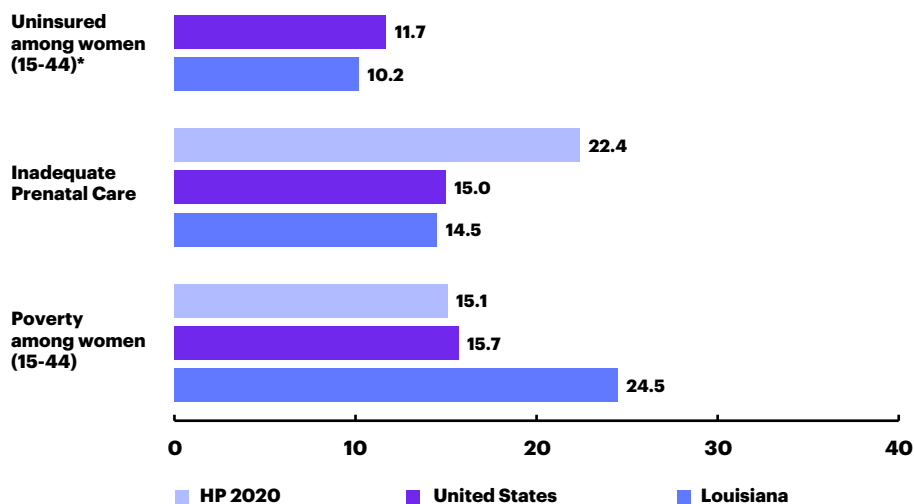
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LOUISIANA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$60
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$12.12
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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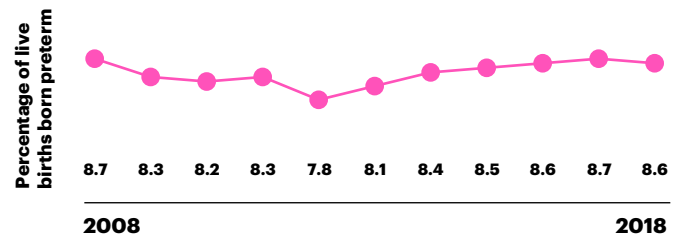
MAINE

PREMATURITY
GRADE

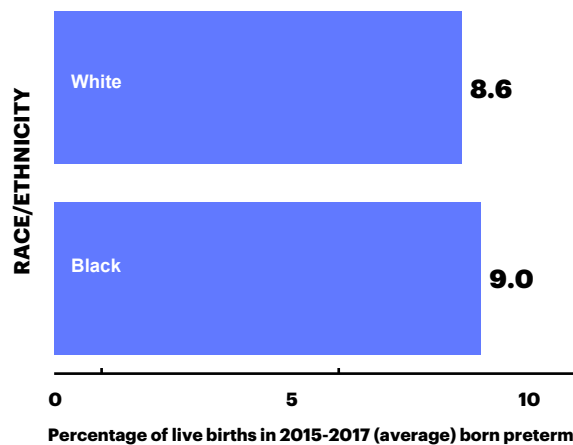
B

PRETERM
BIRTH RATE

8.6%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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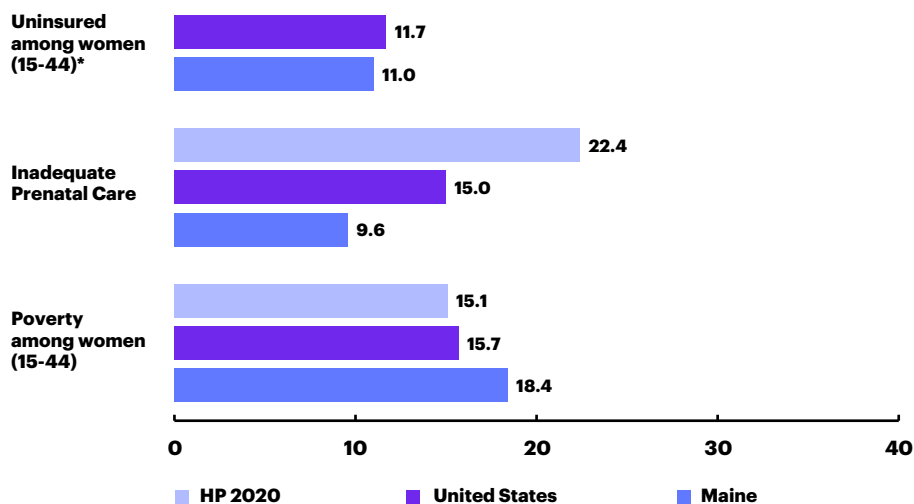
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Androscoggin	A-	8.1%	Improved
Aroostook	D+	10.4%	Worsened
Cumberland	A-	7.9%	Worsened
Kennebec	D+	10.5%	Worsened
Penobscot	B	8.9%	Improved
York	B-	9.0%	Improved

MAINE MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$57 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$3.31 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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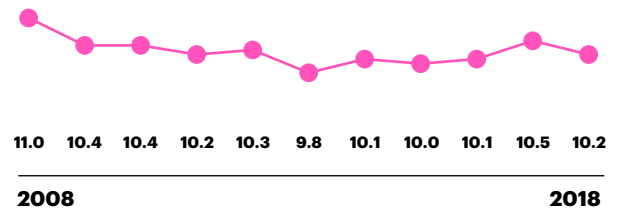
MARYLAND

PREMATURITY
GRADE

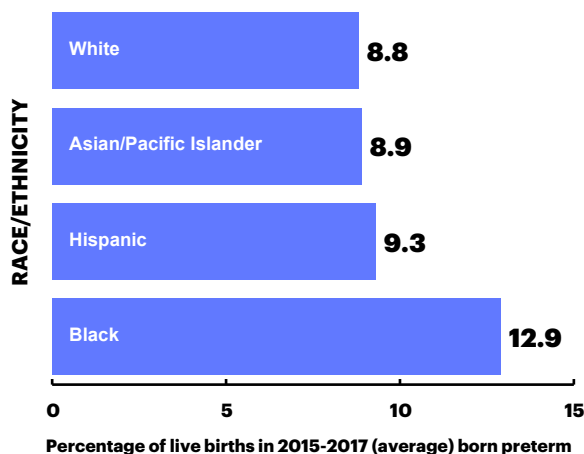
C-

PRETERM
BIRTH RATE

10.2%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Maryland, the preterm birth rate among black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.17

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Anne Arundel	C	9.8%	Worsened
Baltimore	F	11.5%	Worsened
Howard	C+	9.3%	Improved
Montgomery	B	8.9%	Improved
Prince George's	D	10.8%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Baltimore	F	13.2%	Improved

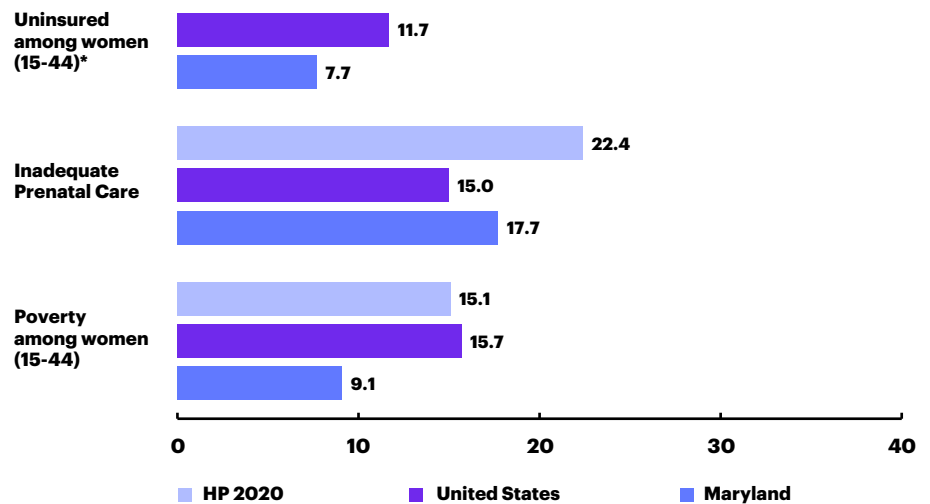
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MARYLAND MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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\$70 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$11.76 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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This year, in addition to monitoring progress on key indicators, Report Cards include selected state actions to improve maternal and infant health. Premature birth and its complications are the largest contributors to infant death in the U.S., and preterm birth rates have been increasing for four years. Prematurity grades are assigned by comparing the 2018 preterm birth rate to March of Dimes' goal of 8.1 percent by 2020. While it's not yet possible to assign grades for maternal health indicators given the available data, it's clear that rates of maternal death and morbidity are unacceptably high. Maternal health complications, and the social determinants of health, affect the health and survival of both mom and baby. Highlighted on the second page are selected actions available to states to help improve maternal and infant health.

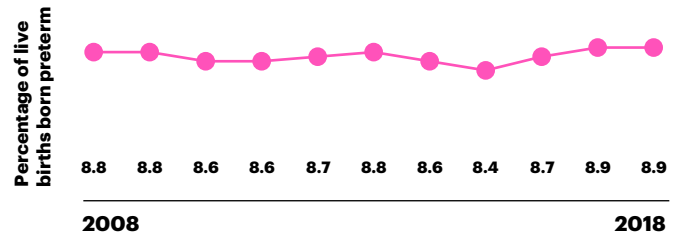
MASSACHUSETTS

PREMATURITY
GRADE

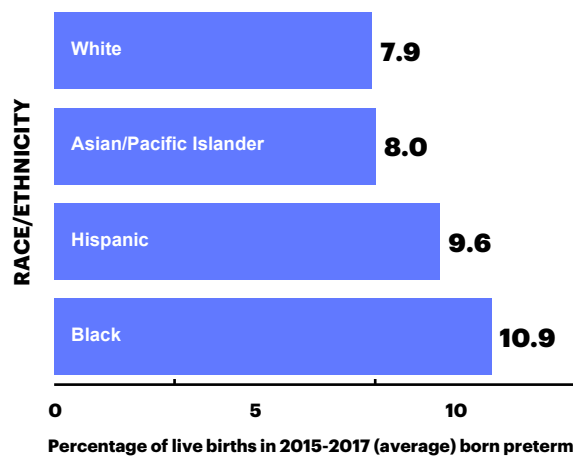
B

PRETERM
BIRTH RATE

8.9%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

The March of Dimes disparity ratio measures and tracks progress towards the elimination of racial/ethnic disparities in preterm birth. It's based on Healthy People 2020 methodology and compares the group with the lowest preterm birth rate to the average for all other groups. Progress is evaluated by comparing the current disparity ratio to a baseline disparity ratio. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.



In Massachusetts, the preterm birth rate among black women is 31% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bristol	C+	9.4%	Worsened
Essex	B	8.9%	Improved
Middlesex	B	8.6%	Worsened
Norfolk	B+	8.4%	Improved
Suffolk	C+	9.6%	Worsened
Worcester	B+	8.2%	No change

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Boston	C	9.9%	Worsened

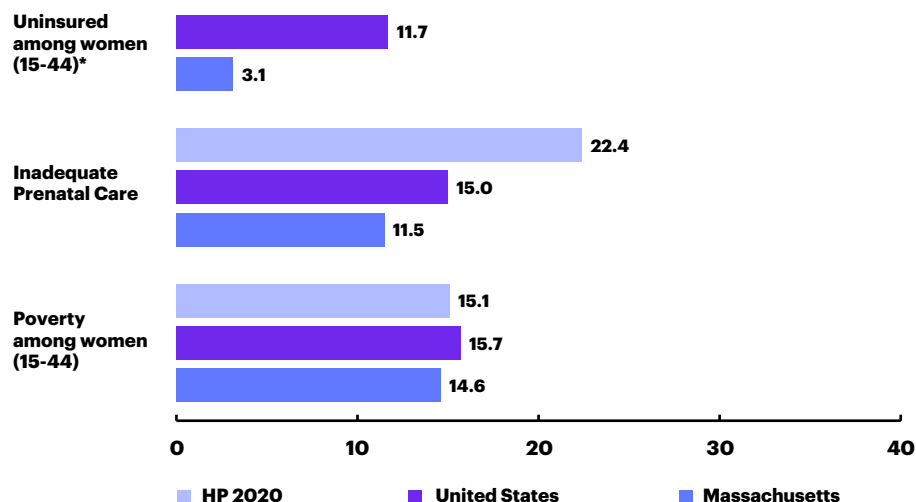
MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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MASSACHUSETTS MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$71
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$10.93
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
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- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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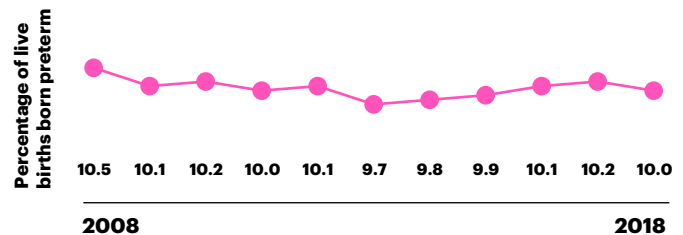
MICHIGAN

PREMATURITY
GRADE

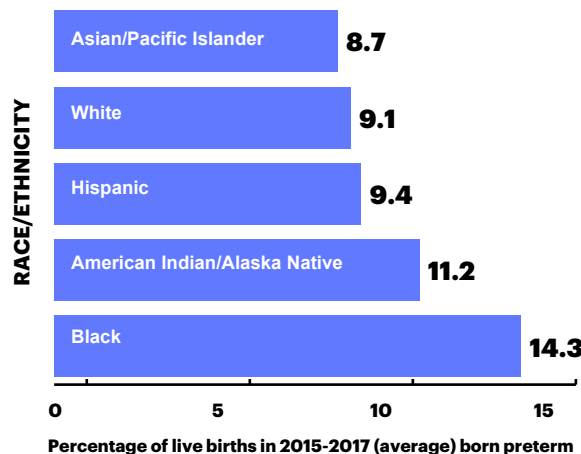
C

PRETERM
BIRTH RATE

10.0%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Michigan, the preterm birth rate among black women is 57% higher than the rate among all other women.

DISPARITY RATIO:

1.21

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Genesee	F	12.4%	No change
Kent	C	9.8%	Improved
Macomb	D-	11.2%	Worsened
Oakland	C-	10.1%	No change
Washtenaw	C+	9.3%	Improved
Wayne	F	11.8%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Detroit	F	14.3%	Improved

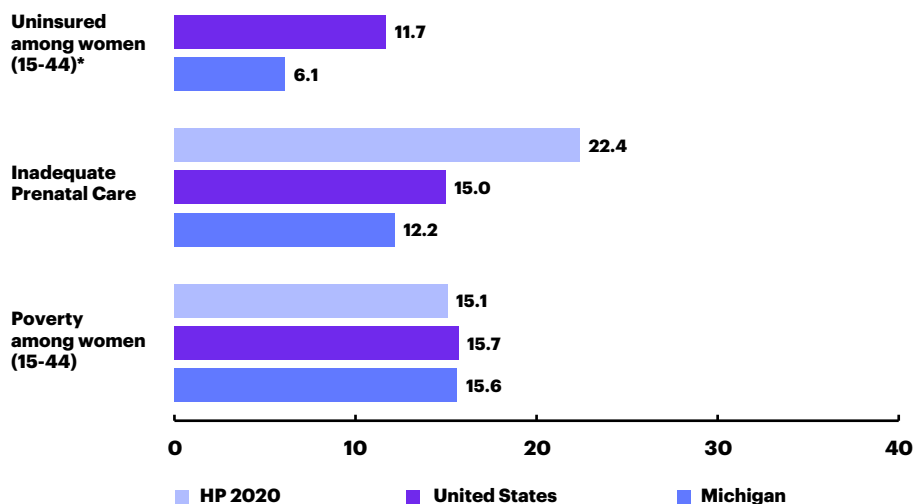
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MICHIGAN MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

\$64 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$18.86 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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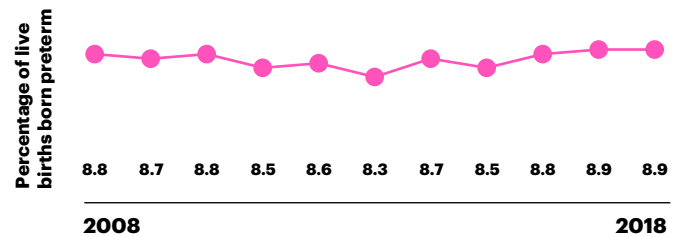
MINNESOTA

PREMATURITY
GRADE

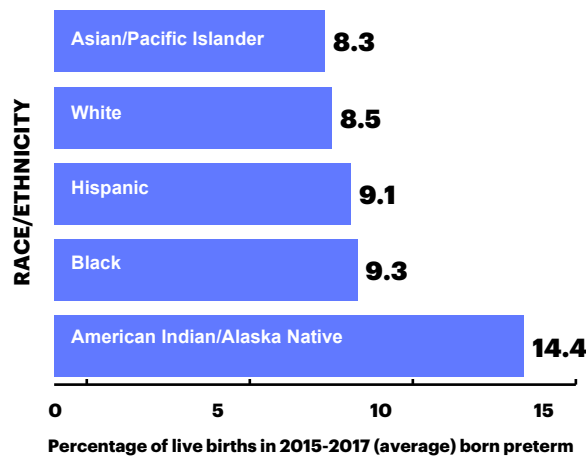
B

PRETERM
BIRTH RATE

8.9%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Minnesota, the preterm birth rate among American Indian/Alaska Native women is 67% higher than the rate among all other women.

DISPARITY RATIO:

1.24

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Anoka	A-	8.0%	Worsened
Dakota	B	8.7%	Improved
Hennepin	C+	9.6%	Worsened
Olmsted	A	7.3%	Improved
Ramsey	B	8.7%	Worsened
Washington	A-	7.9%	No change

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Minneapolis	D+	10.5%	Worsened

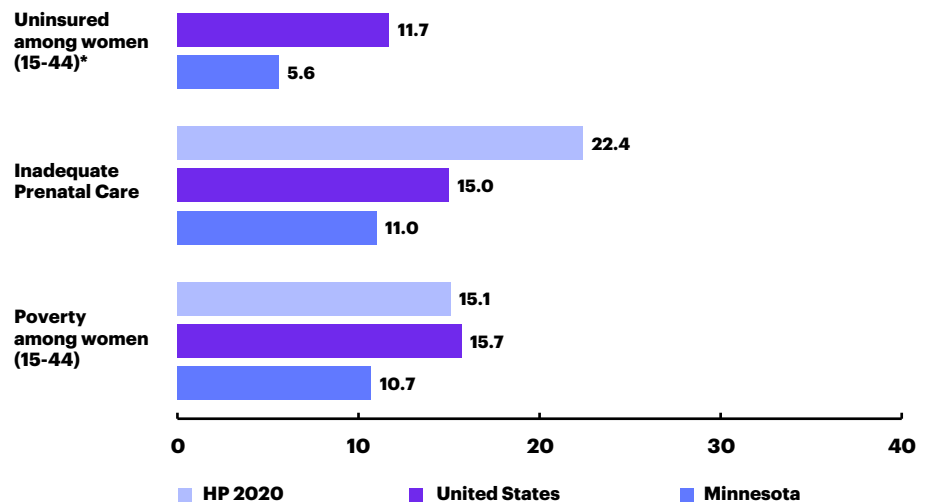
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MINNESOTA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$64
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$9.10
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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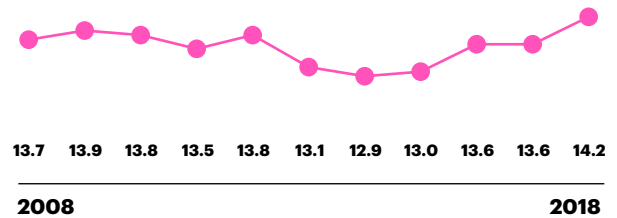
MISSISSIPPI

PREMATURITY
GRADE

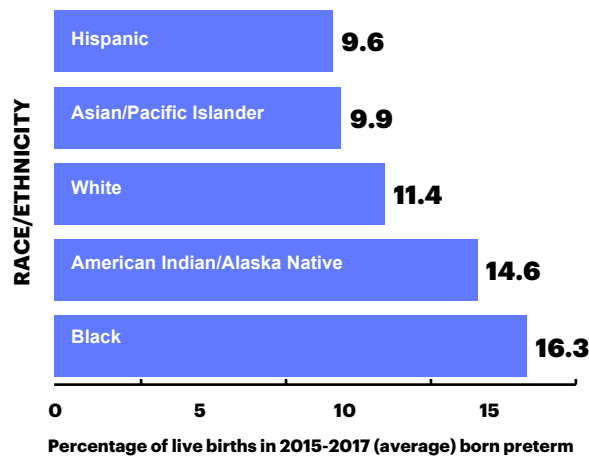
F

PRETERM
BIRTH RATE

14.2%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Mississippi, the preterm birth rate among black women is 44% higher than the rate among all other women.

DISPARITY RATIO:

1.36

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
DeSoto	D+	10.5%	Worsened
Harrison	D+	10.6%	Improved
Hinds	F	16.2%	Worsened
Jackson	F	12.2%	Improved
Madison	F	12.9%	Worsened
Rankin	F	13.4%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jackson	F	17.3%	Worsened

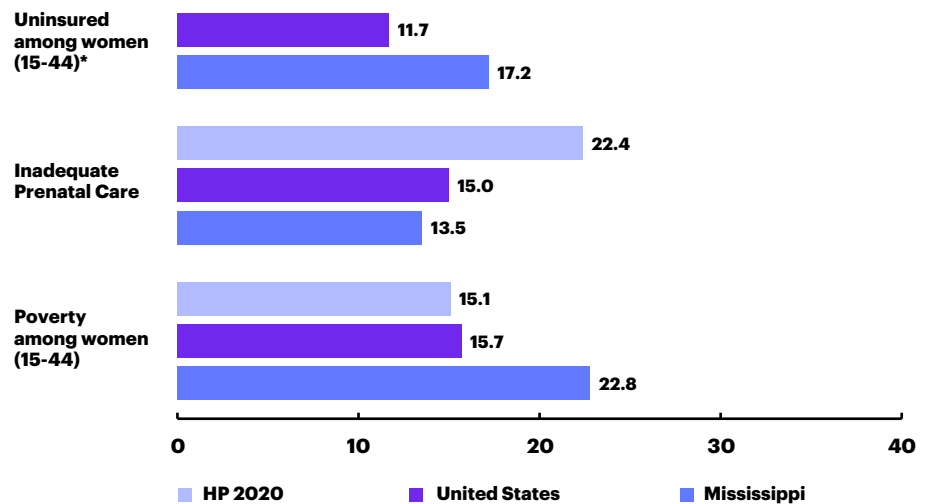
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MISSISSIPPI MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$58
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$9.23
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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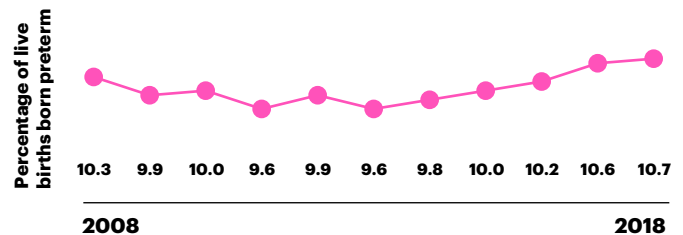
MISSOURI

PREMATURITY
GRADE

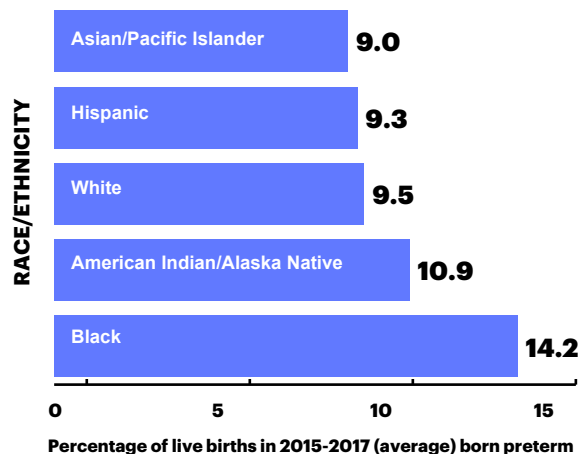
D+

PRETERM
BIRTH RATE

10.7%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Missouri, the preterm birth rate among black women is 49% higher than the rate among all other women.

DISPARITY RATIO:

1.23

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Clay	B+	8.5%	Improved
Greene	C-	10.2%	Worsened
Jackson	D+	10.6%	Worsened
St. Charles	C	9.9%	Improved
St. Louis	D-	11.2%	Improved
St. Louis (city)	F	13.7%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Kansas City	D+	10.7%	Improved

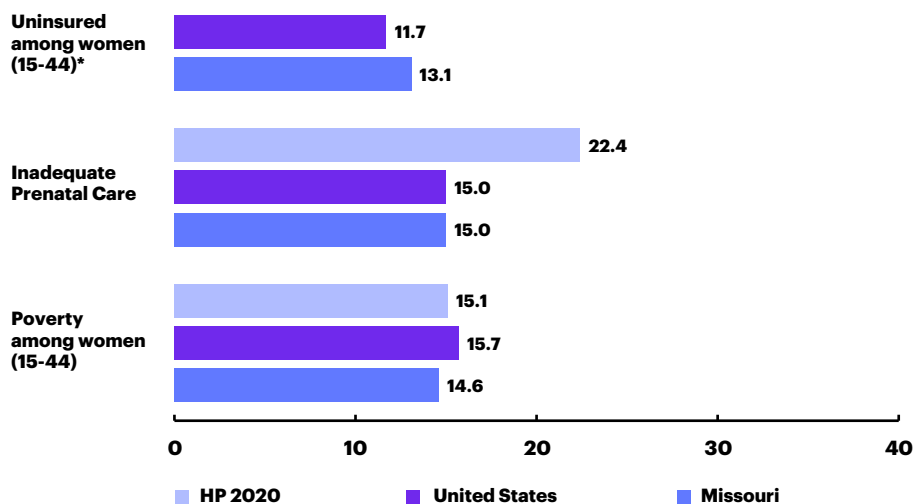
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MISSOURI MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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**\$59
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$12.19
MILLION**

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NOT ADOPTED

MEDICAID EXPANSION

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2019
MARCH OF DIMES
REPORT CARD

This year, in addition to monitoring progress on key indicators, Report Cards include selected state actions to improve maternal and infant health. Premature birth and its complications are the largest contributors to infant death in the U.S., and preterm birth rates have been increasing for four years. Prematurity grades are assigned by comparing the 2018 preterm birth rate to March of Dimes' goal of 8.1 percent by 2020. While it's not yet possible to assign grades for maternal health indicators given the available data, it's clear that rates of maternal death and morbidity are unacceptably high. Maternal health complications, and the social determinants of health, affect the health and survival of both mom and baby. Highlighted on the second page are selected actions available to states to help improve maternal and infant health.

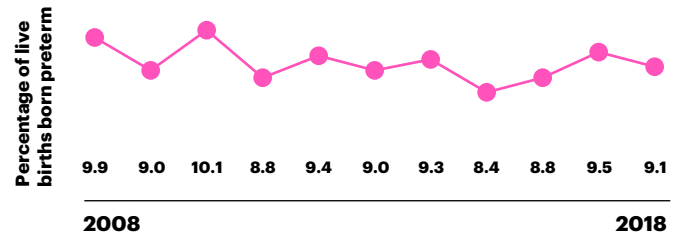
MONTANA

PREMATURITY
GRADE

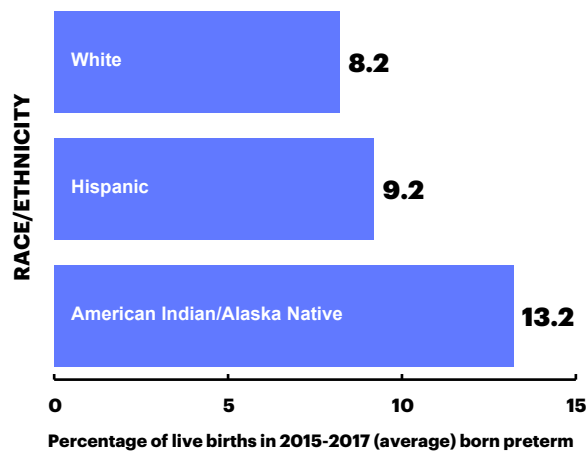
B-

PRETERM
BIRTH RATE

9.1%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Montana, the preterm birth rate among American Indian/Alaska Native women is 59% higher than the rate among all other women.

DISPARITY RATIO:

1.37

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cascade	D	11.1%	Worsened
Flathead	A	7.5%	Worsened
Gallatin	A	7.7%	Improved
Lewis and Clark	A-	8.0%	Worsened
Missoula	A-	7.9%	Worsened
Yellowstone	C-	10.1%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Billings	C-	10.3%	Worsened

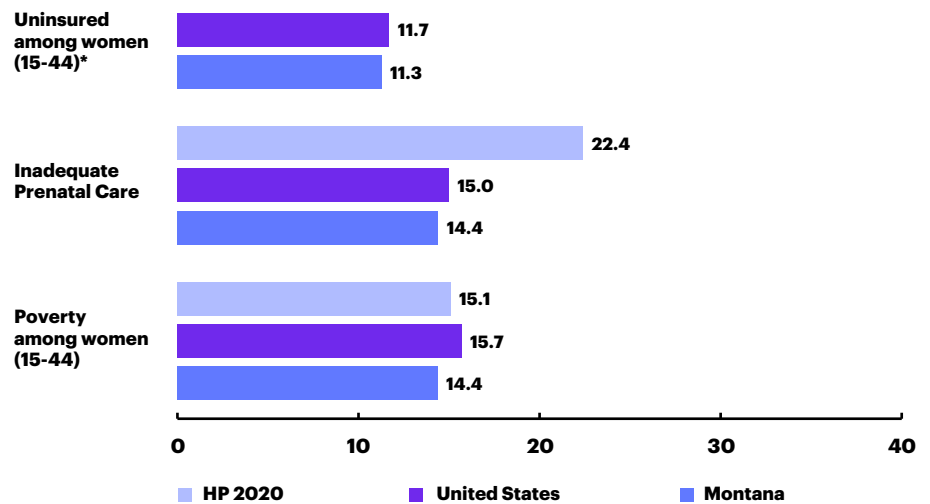
MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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MONTANA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$60
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$2.30
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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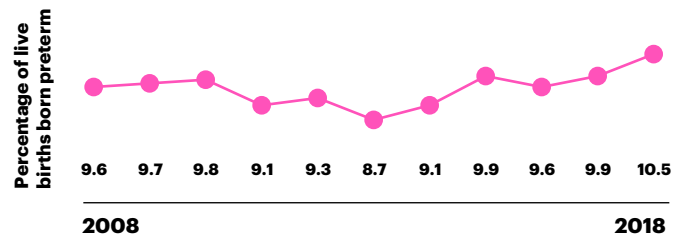
NEBRASKA

PREMATURITY
GRADE

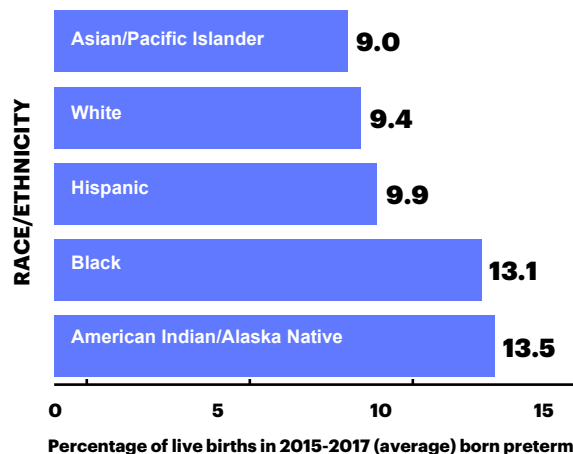
D+

PRETERM
BIRTH RATE

10.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Nebraska, the preterm birth rate among American Indian/Alaska Native women is 39% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Buffalo	D-	11.3%	Worsened
Douglas	D	11.1%	Worsened
Hall	B+	8.2%	Improved
Lancaster	D+	10.5%	Worsened
Madison	A-	7.8%	Worsened
Sarpy	C+	9.6%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Omaha	D-	11.2%	Worsened

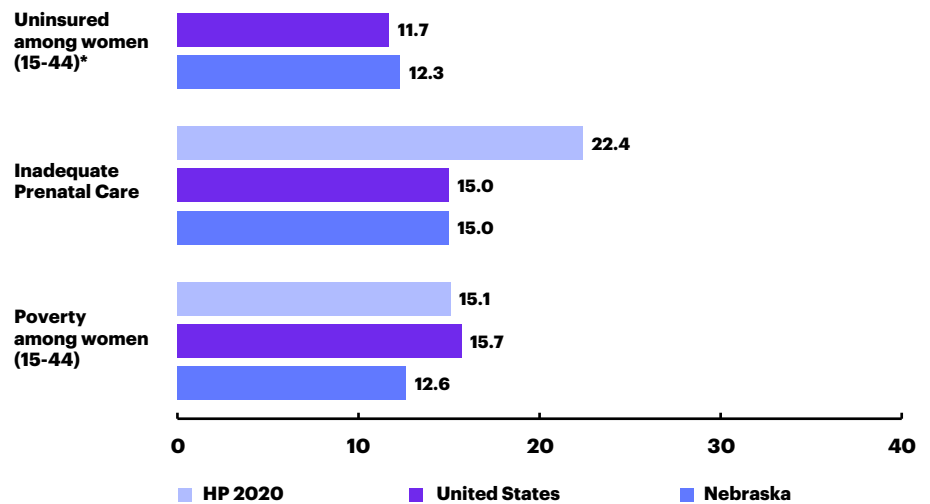
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NEBRASKA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$56
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$4.02
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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**ADOPTED
BUT NOT
IMPLEMENTED**

MEDICAID EXPANSION

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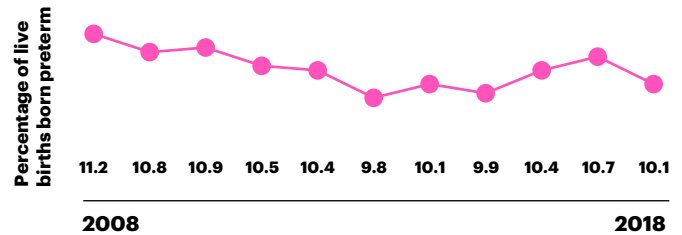
NEVADA

PREMATURITY
GRADE

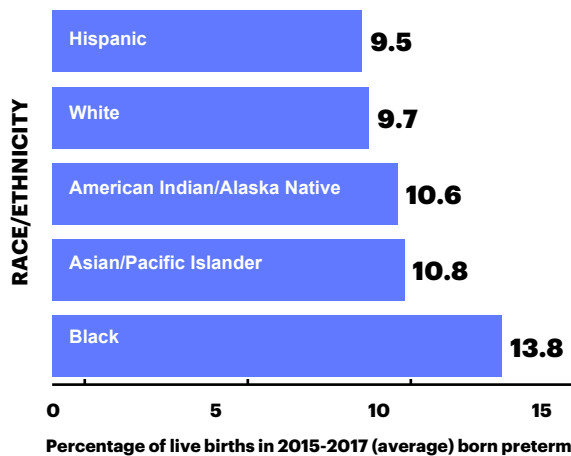
C-

PRETERM
BIRTH RATE

10.1%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Nevada, the preterm birth rate among black women is 41% higher than the rate among all other women.

DISPARITY RATIO:

1.04

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Carson City (city)	C	9.9%	Improved
Clark	D	11.1%	Worsened
Elko	C+	9.5%	Improved
Lyon	C+	9.5%	Improved
Nye	F	12.3%	Worsened
Washoe	C+	9.6%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Las Vegas	D	11.1%	Worsened

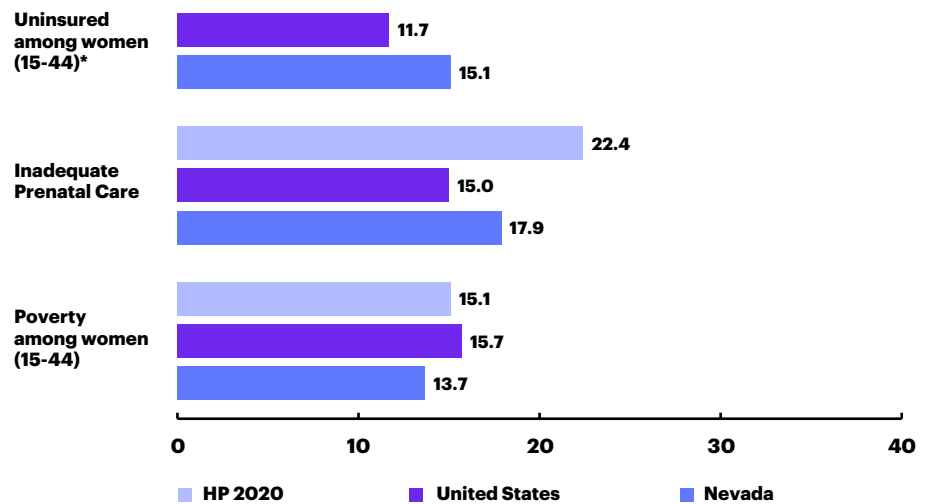
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NEVADA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$2.12
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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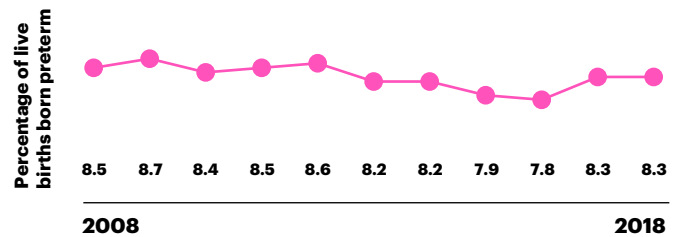
NEW HAMPSHIRE

PREMATURITY
GRADE

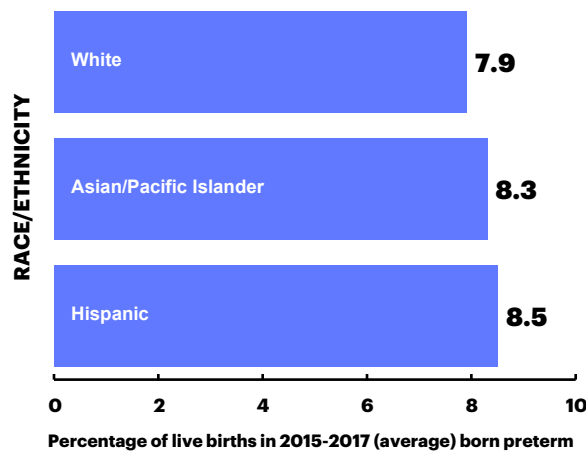
B+

PRETERM
BIRTH RATE

8.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In New Hampshire, the preterm birth rate among Asian/Pacific Islander and Hispanic women is 8% higher than the rate among all other women.

DISPARITY RATIO:

1.01

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cheshire	A-	7.9%	Improved
Grafton	B+	8.3%	Worsened
Hillsborough	B+	8.2%	Worsened
Merrimack	A	7.7%	Worsened
Rockingham	B+	8.5%	Worsened
Strafford	C	9.7%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Manchester	C+	9.3%	Worsened

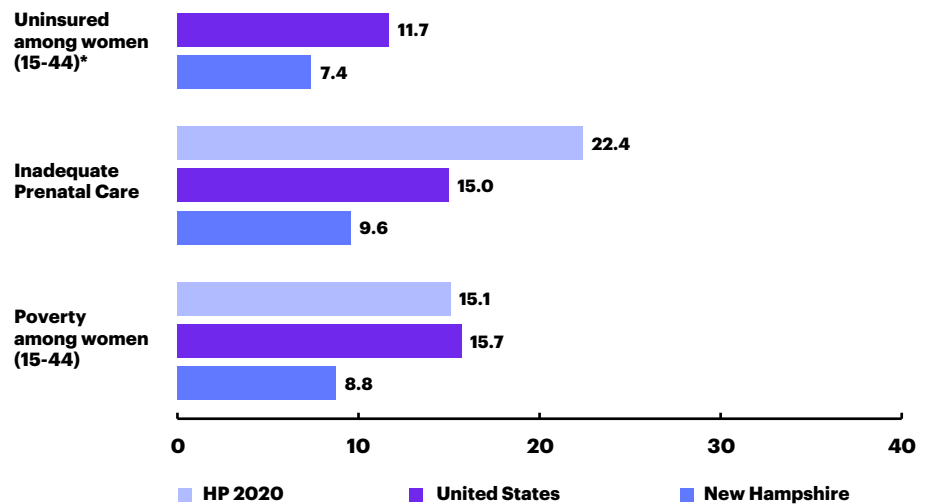
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NEW HAMPSHIRE MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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**\$64
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$1.97
MILLION**

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ADOPTED

MEDICAID EXPANSION

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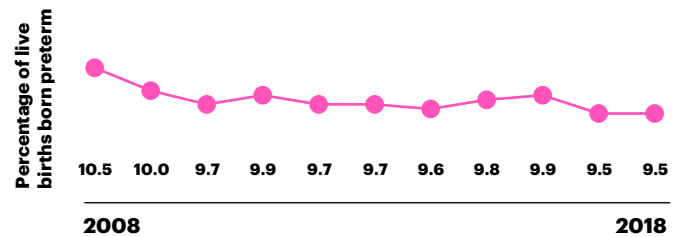
NEW JERSEY

PREMATURITY
GRADE

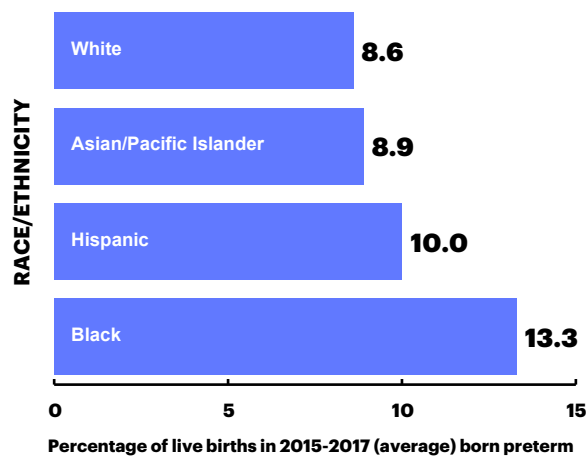
C+

PRETERM
BIRTH RATE

9.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In New Jersey, the preterm birth rate among black women is 46% higher than the rate among all other women.

DISPARITY RATIO:

1.19

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bergen	C+	9.6%	Improved
Essex	D+	10.6%	Improved
Hudson	C+	9.5%	Improved
Middlesex	B	8.9%	No change
Ocean	A	7.7%	Improved
Union	B	8.8%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Jersey City	D+	10.4%	Improved

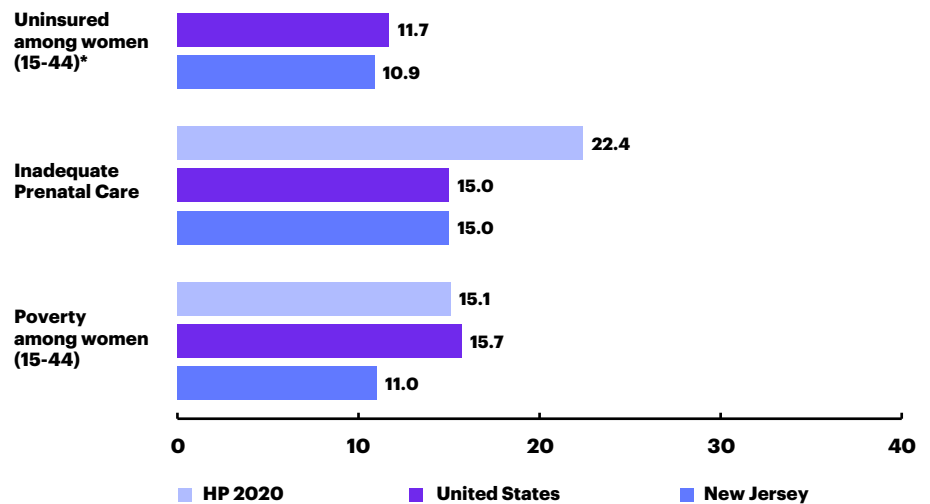
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NEW JERSEY MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$72
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$11.64
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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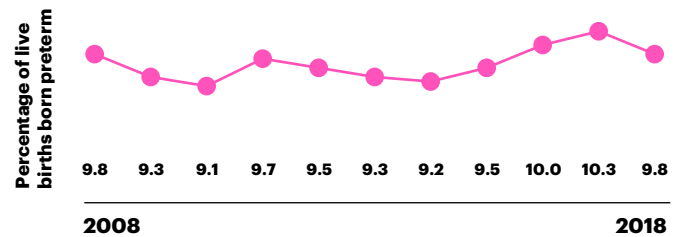
NEW MEXICO

PREMATURITY
GRADE

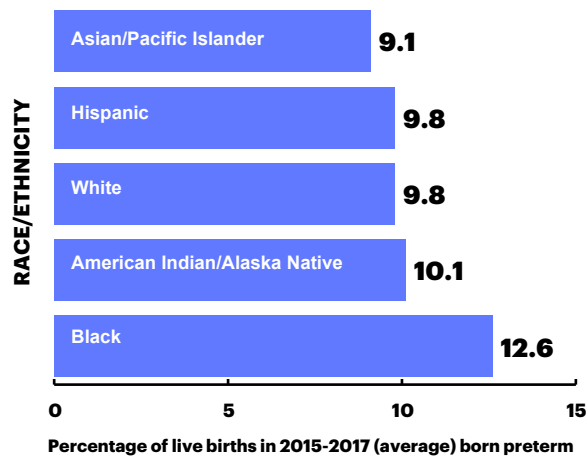
C

PRETERM
BIRTH RATE

9.8%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In New Mexico, the preterm birth rate among black women is 29% higher than the rate among all other women.

DISPARITY RATIO:

1.02

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bernalillo	C-	10.1%	Improved
Dona Ana	C+	9.3%	Worsened
Lea	F	12.0%	Worsened
San Juan	B	8.8%	Improved
Sandoval	C-	10.3%	Improved
Santa Fe	D	11.1%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Albuquerque	C-	10.2%	Improved

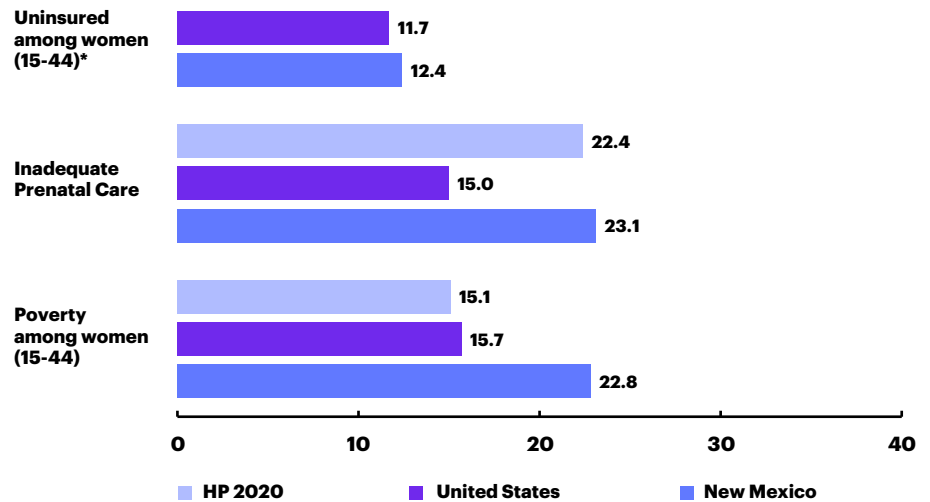
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NEW MEXICO MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$62
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$4.13
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

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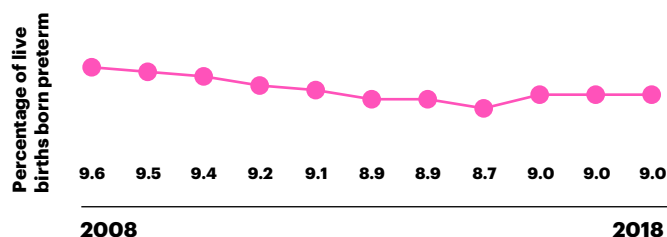
NEW YORK

PREMATURITY
GRADE

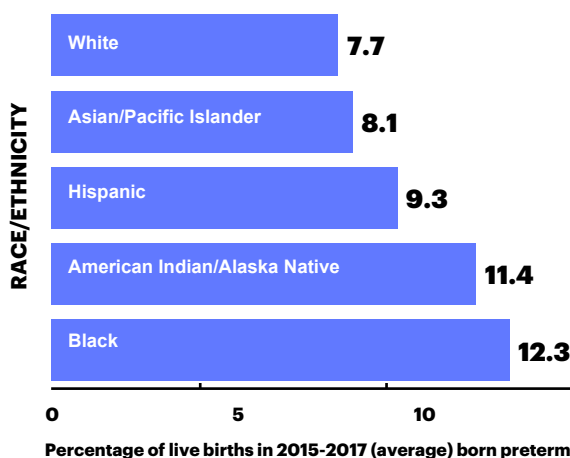
B-

PRETERM
BIRTH RATE

9.0%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In New York, the preterm birth rate among black women is 48% higher than the rate among all other women.

DISPARITY RATIO:

1.26

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bronx	C	10.0%	Worsened
Kings(Brooklyn)	B+	8.5%	Improved
Nassau	B-	9.2%	Improved
New York (Manhattan)	B	8.6%	No change
Queens	B	8.8%	Worsened
Suffolk	C	9.9%	No change

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
New York	B	8.9%	Worsened

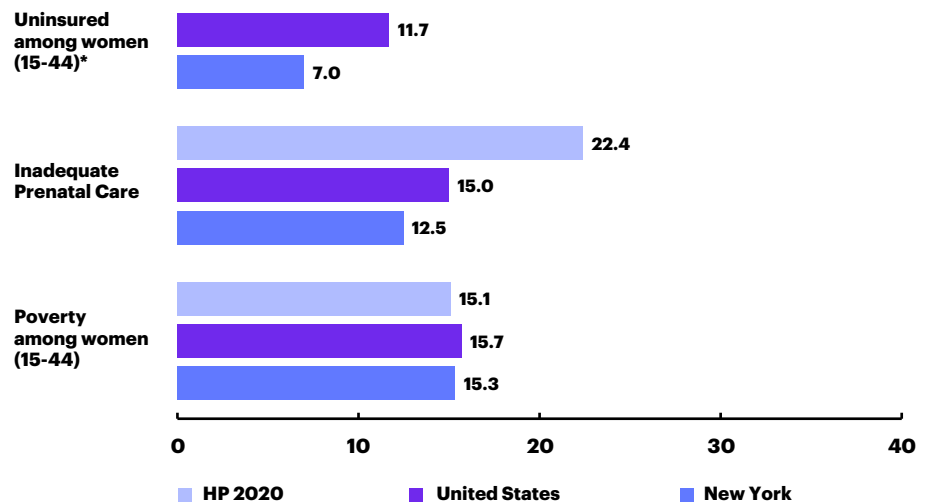
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NEW YORK MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$73
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$38.09
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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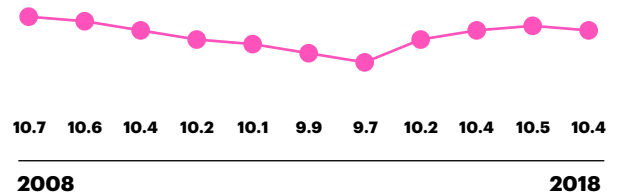
NORTH CAROLINA

PREMATURITY
GRADE

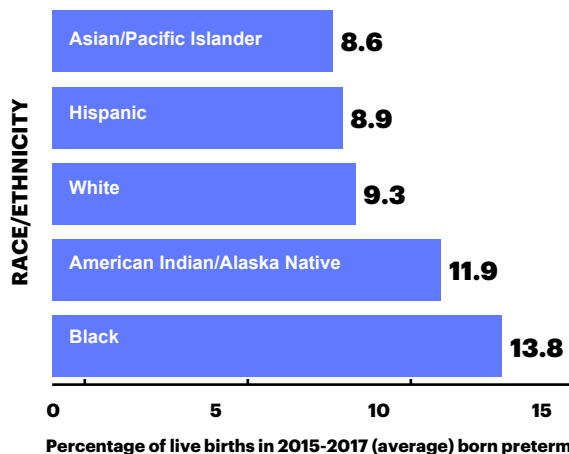
D+

PRETERM
BIRTH RATE

10.4%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In North Carolina, the preterm birth rate among black women is 48% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

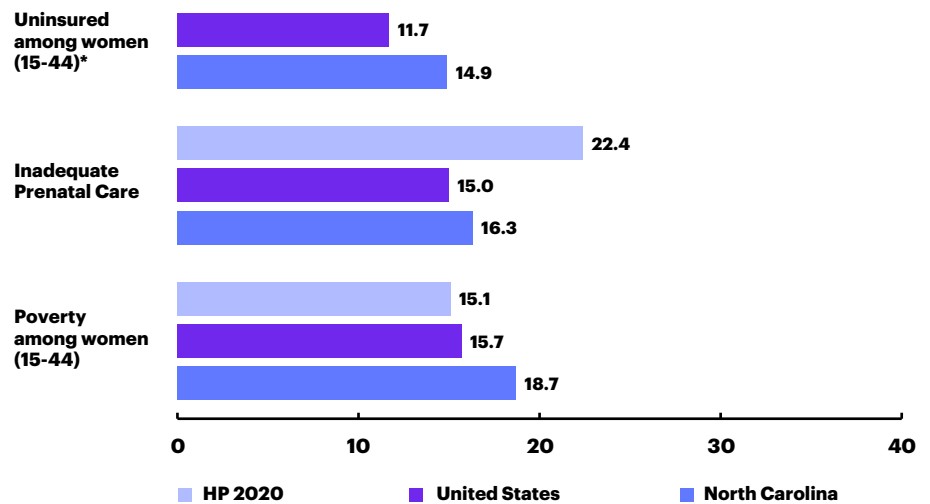
COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cumberland	D-	11.2%	Improved
Durham	C-	10.1%	Worsened
Forsyth	F	12.6%	Worsened
Guilford	D	10.8%	Worsened
Mecklenburg	C-	10.3%	Worsened
Wake	B	8.9%	No change

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Charlotte	D+	10.5%	Worsened

NORTH CAROLINA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$64
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$17.41
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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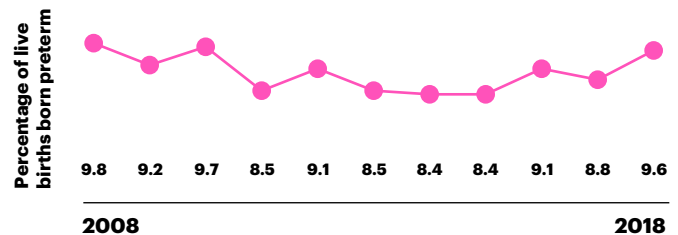
NORTH DAKOTA

PREMATURITY
GRADE

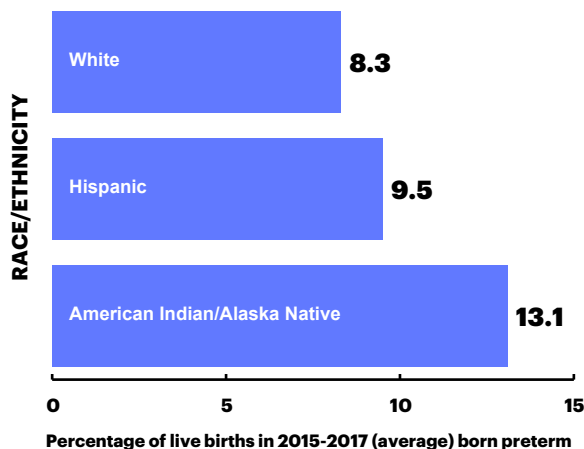
C+

PRETERM
BIRTH RATE

9.6%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In North Dakota, the preterm birth rate among American Indian/Alaska Native women is 56% higher than the rate among all other women.

DISPARITY RATIO:

1.36

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Burleigh	B	8.9%	Worsened
Cass	B	8.6%	Worsened
Grand Forks	C+	9.5%	Improved
Stark	A	6.3%	Improved
Ward	A	7.5%	Improved
Williams	A	6.9%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Fargo	A-	8.1%	Improved

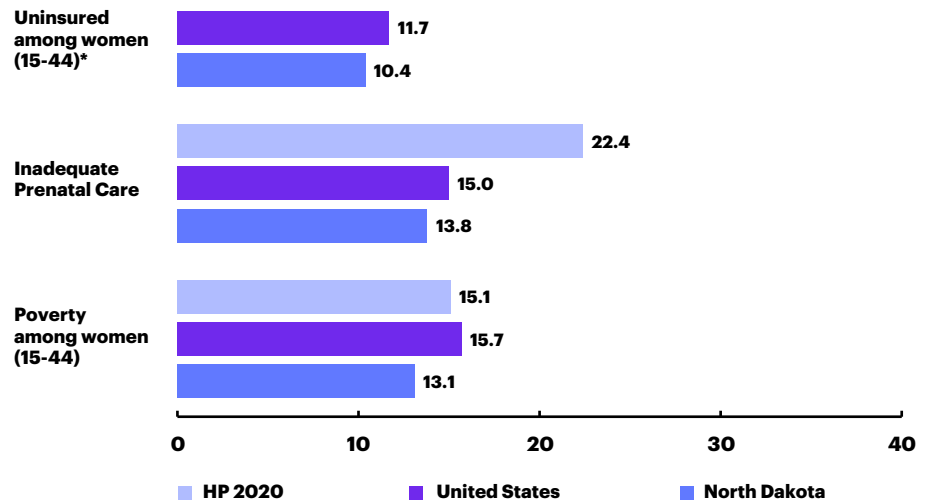
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NORTH DAKOTA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$66
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$1.74
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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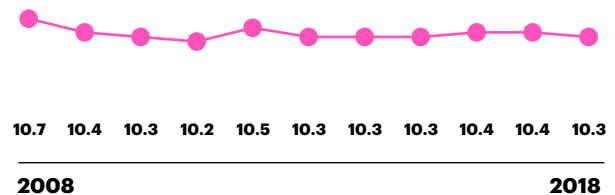
OHIO

PREMATURITY
GRADE

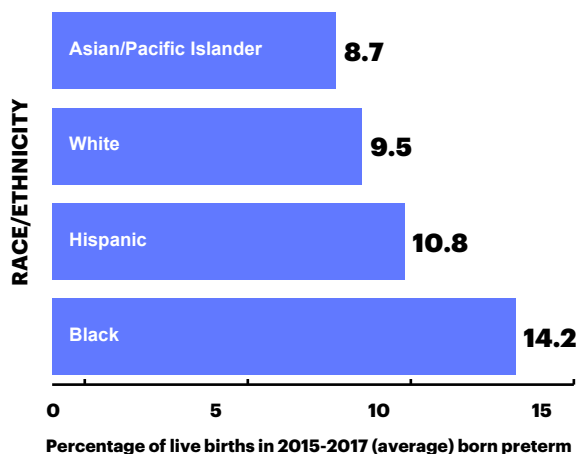
C-

PRETERM
BIRTH RATE

10.3%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Ohio, the preterm birth rate among black women is 49% higher than the rate among all other women.

DISPARITY RATIO:

1.33

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cuyahoga	F	12.2%	Worsened
Franklin	D+	10.5%	Improved
Hamilton	D	11.1%	Worsened
Lucas	F	11.6%	Worsened
Montgomery	F	11.7%	Worsened
Summit	B-	9.2%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Columbus	D	10.9%	Improved

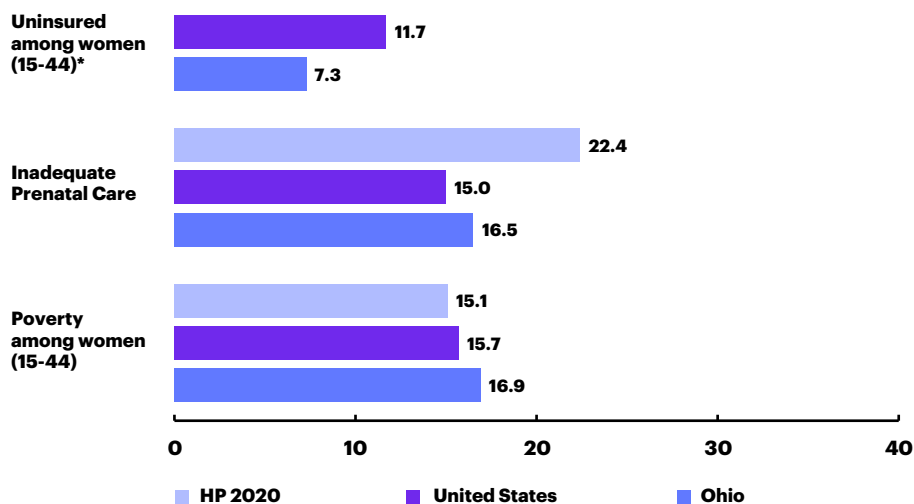
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OHIO MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$62
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$21.96
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
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2019
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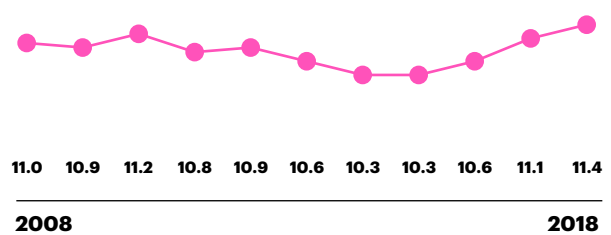
OKLAHOMA

PREMATURITY
GRADE

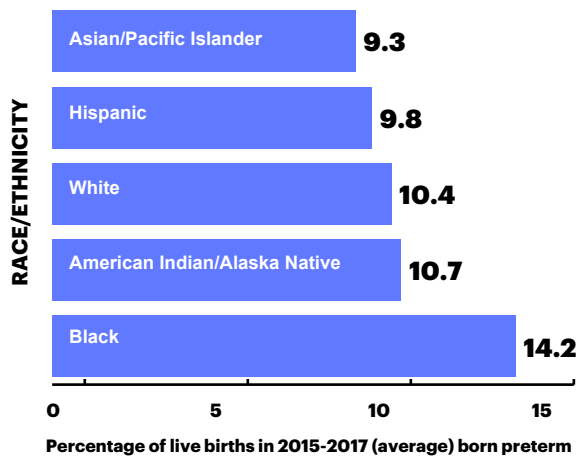
D-

PRETERM
BIRTH RATE

11.4%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Oklahoma, the preterm birth rate among black women is 38% higher than the rate among all other women.

DISPARITY RATIO:

1.14

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Canadian	D-	11.4%	Worsened
Cleveland	C-	10.2%	Improved
Comanche	C	9.7%	Improved
Oklahoma	F	11.7%	Worsened
Rogers	F	11.8%	Worsened
Tulsa	D-	11.3%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Oklahoma City	F	12.2%	Worsened

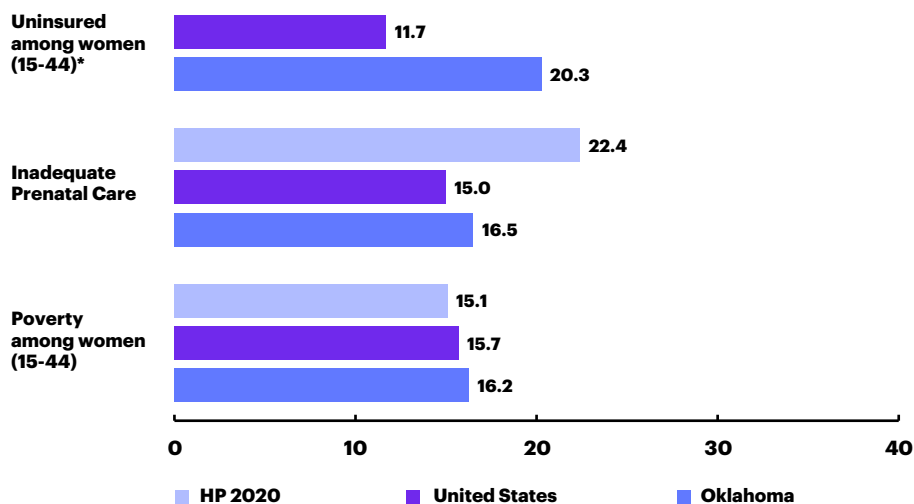
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OKLAHOMA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$54
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$7.05
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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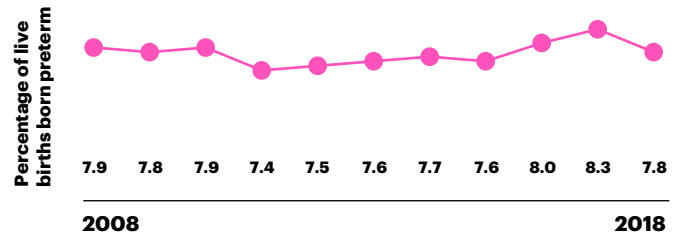
OREGON

PREMATURITY
GRADE

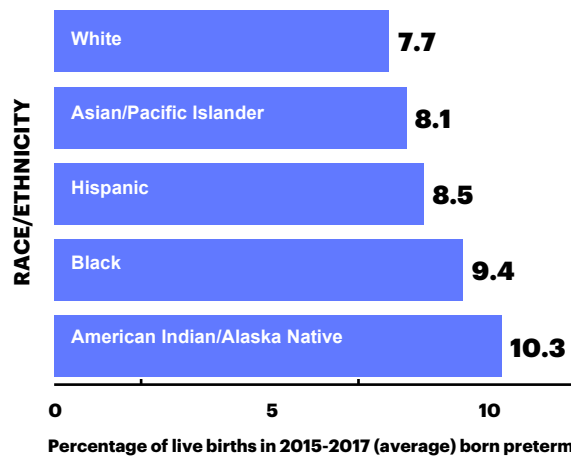
A-

PRETERM
BIRTH RATE

7.8%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Oregon, the preterm birth rate among American Indian/Alaska Native women is 30% higher than the rate among all other women.

DISPARITY RATIO:

1.18

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Clackamas	B	8.6%	Worsened
Jackson	C+	9.6%	Worsened
Lane	B+	8.3%	Worsened
Marion	C+	9.6%	Worsened
Multnomah	B+	8.4%	Worsened
Washington	A	7.6%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Portland	A-	8.1%	Worsened

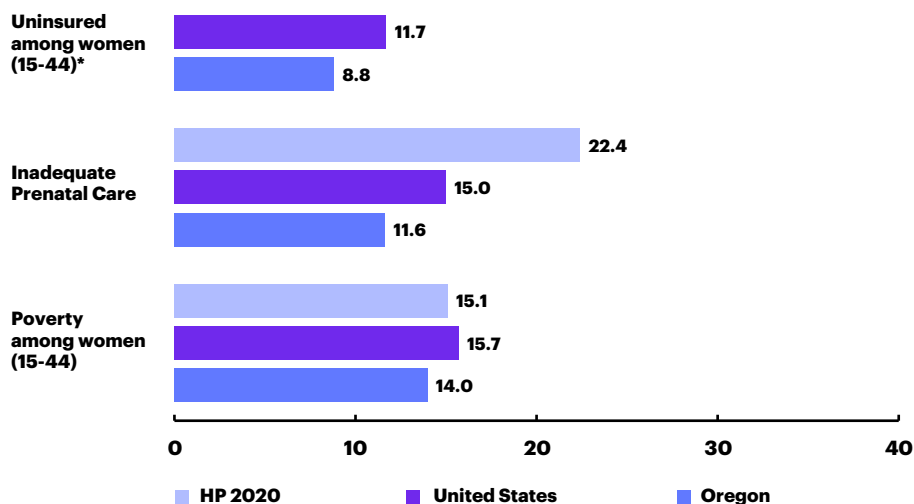
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OREGON MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$64
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$6.17
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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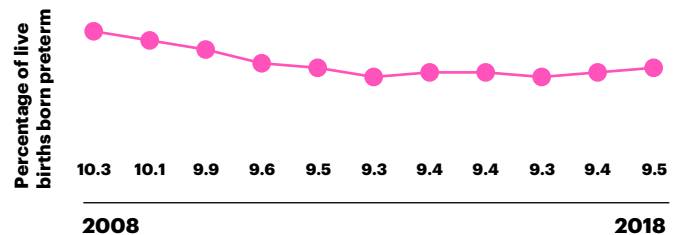
PENNSYLVANIA

PREMATURITY
GRADE

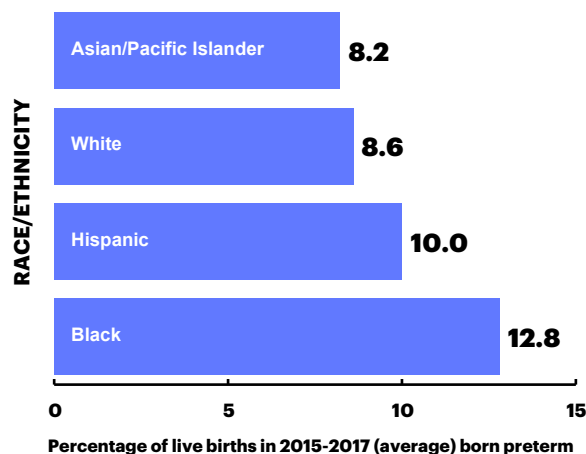
C+

PRETERM
BIRTH RATE

9.5%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Pennsylvania, the preterm birth rate among black women is 47% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Allegheny	C	9.8%	Worsened
Bucks	C+	9.3%	Worsened
Delaware	C+	9.4%	Improved
Lancaster	B-	9.1%	Improved
Montgomery	A-	7.8%	No change
Philadelphia	C	10.0%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Philadelphia	C	10.0%	Improved

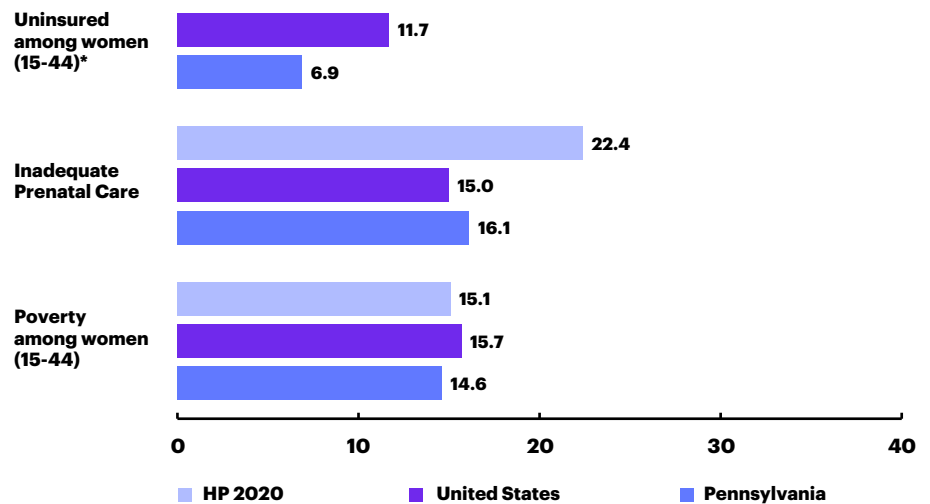
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PENNSYLVANIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$23.73
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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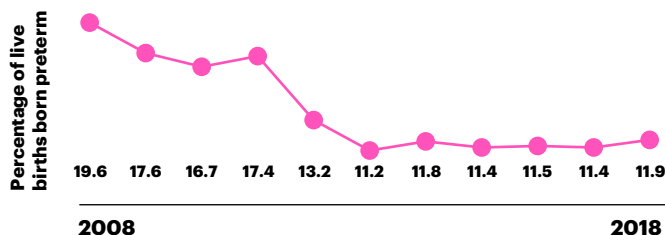
PUERTO RICO

PREMATURITY
GRADE

F

PRETERM
BIRTH RATE

11.9%



PRETERM BIRTH RATES BY MUNICIPALITIES

MUNICIPALITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bayamón	B	8.7%	Improved
Caguas	F	15.8%	Worsened
Carolina	C	9.7%	Improved
Ponce	F	12.6%	Worsened
San Juan	F	12.0%	Worsened

PUERTO RICO MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

**15.79
MILLION**

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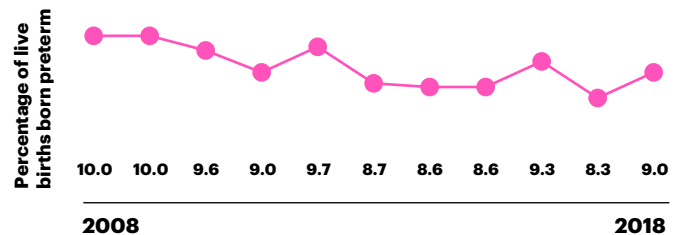
RHODE ISLAND

PREMATURITY
GRADE

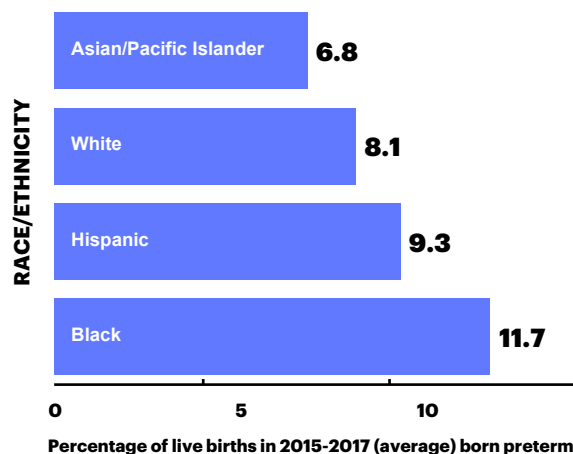
B-

PRETERM
BIRTH RATE

9.0%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Rhode Island, the preterm birth rate among black women is 39% higher than the rate among all other women.

DISPARITY RATIO:

1.14

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bristol	B+	8.5%	Worsened
Kent	A	7.5%	Improved
Newport	A	6.3%	Improved
Providence	B	8.7%	Improved
Washington	A-	8.0%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Providence	C+	9.6%	Improved

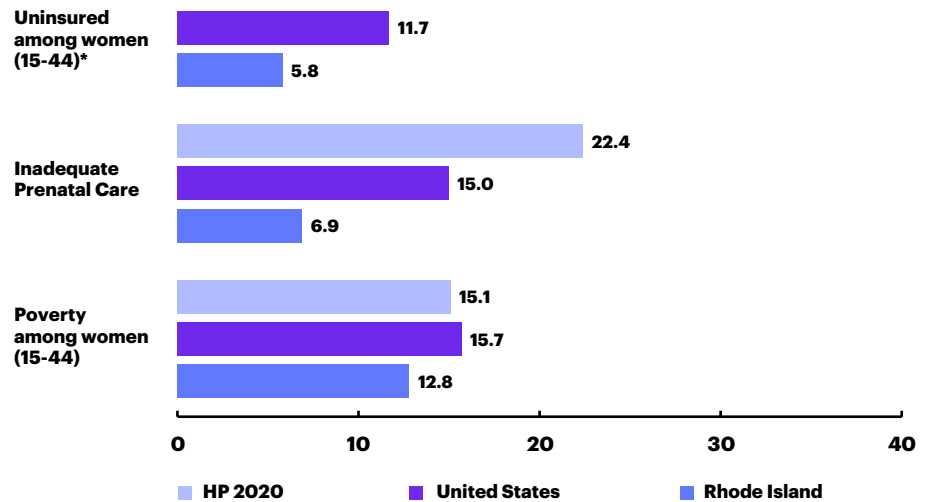
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**\$68
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$1.65
MILLION**

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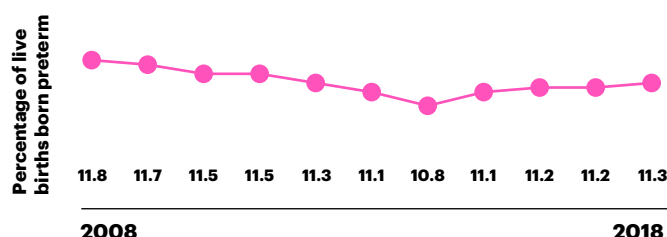
SOUTH CAROLINA

PREMATURITY
GRADE

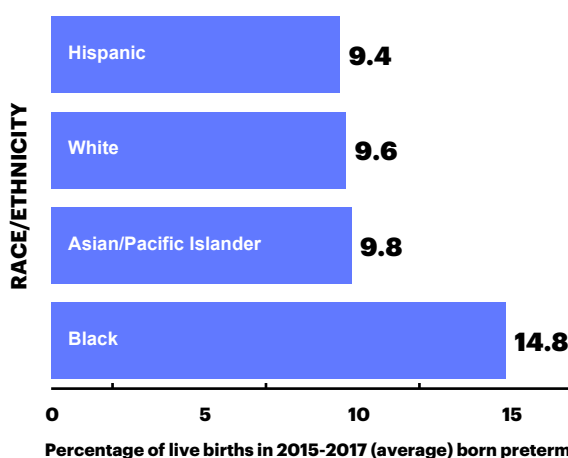
D-

PRETERM
BIRTH RATE

11.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In South Carolina, the preterm birth rate among black women is 56% higher than the rate among all other women.

DISPARITY RATIO:

1.21

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Charleston	D+	10.6%	Worsened
Greenville	D-	11.3%	Worsened
Horry	D-	11.3%	Improved
Lexington	D	10.8%	Worsened
Richland	F	12.4%	Improved
Spartanburg	D	11.1%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Columbia	F	13.2%	Improved

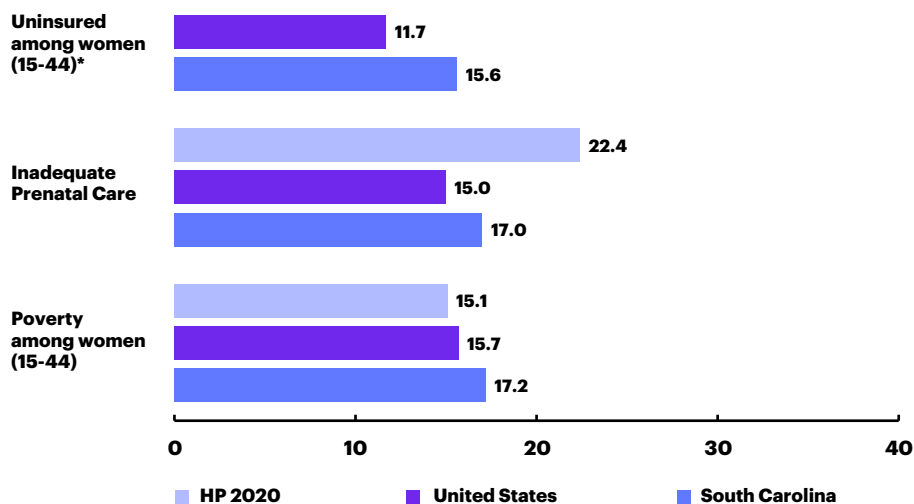
MORE INFORMATION MARCHOFDIMES.ORG/REPORTCARD

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SOUTH CAROLINA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$63
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$11.50
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

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2019
MARCH OF DIMES
REPORT CARD

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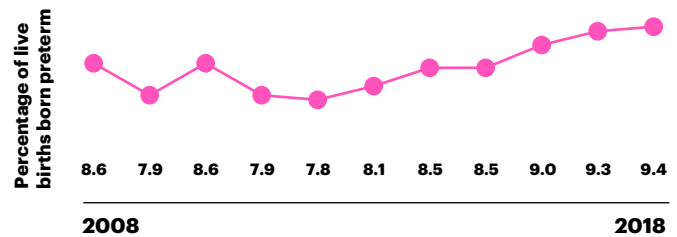
SOUTH DAKOTA

PREMATURITY
GRADE

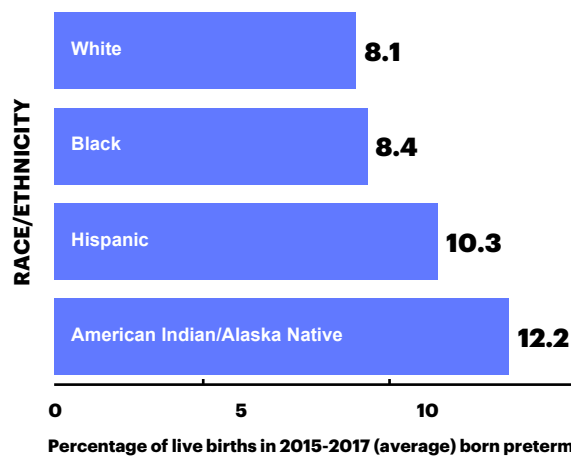
C+

PRETERM
BIRTH RATE

9.4%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In South Dakota, the preterm birth rate among American Indian/Alaska Native women is 47% higher than the rate among all other women.

DISPARITY RATIO:

1.27

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Brookings	A	6.7%	Improved
Brown	A	6.5%	Improved
Codington	B	8.7%	Worsened
Lincoln	B-	9.1%	Worsened
Minnehaha	A-	8.1%	Worsened
Pennington	D+	10.7%	Worsened

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Sioux Falls	B+	8.2%	Worsened

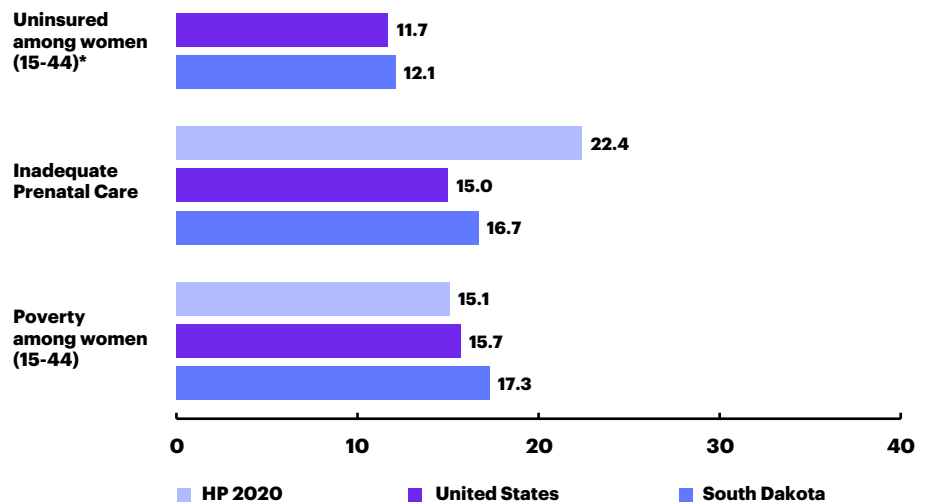
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SOUTH DAKOTA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

Our unequal society has negative consequences for health. Factors such as these are linked to adverse maternal and infant health outcomes overall. Many other structural factors and inequities influence the health of mothers and babies, especially for Black, American Indian and Alaska Native women. For example, income, health insurance status and prenatal care access are traditionally considered protective factors, but if they are held constant, racial and ethnic disparities persist. March of Dimes is collaborating with others to confront social and structural determinants of health, while identifying solutions that help alleviate the negative impacts of such inequities.



*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$54
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$2.17
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

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2019
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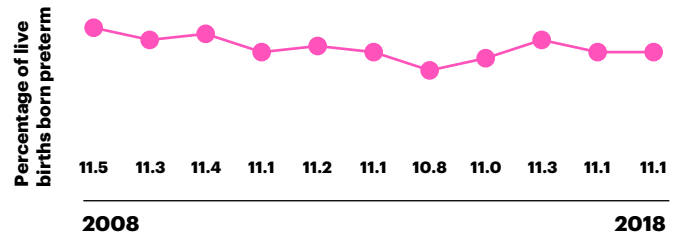
TENNESSEE

PREMATURITY
GRADE

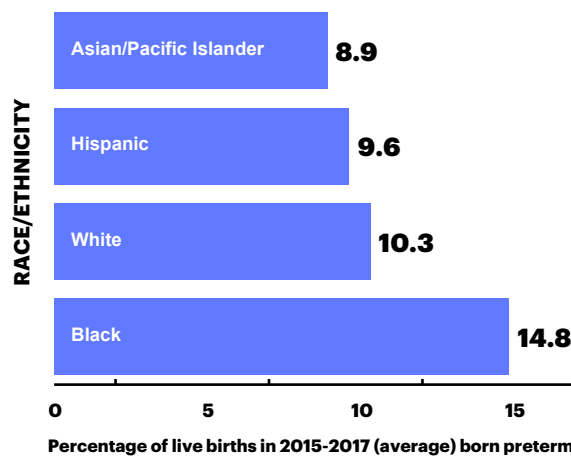
D

PRETERM
BIRTH RATE

11.1%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Tennessee, the preterm birth rate among black women is 45% higher than the rate among all other women.

DISPARITY RATIO:

1.31

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Davidson	D+	10.4%	Improved
Hamilton	D	10.9%	Improved
Knox	C	10.0%	Worsened
Montgomery	C-	10.1%	Worsened
Rutherford	F	12.4%	Worsened
Shelby	F	12.5%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Nashville-Davidson	D+	10.4%	Improved

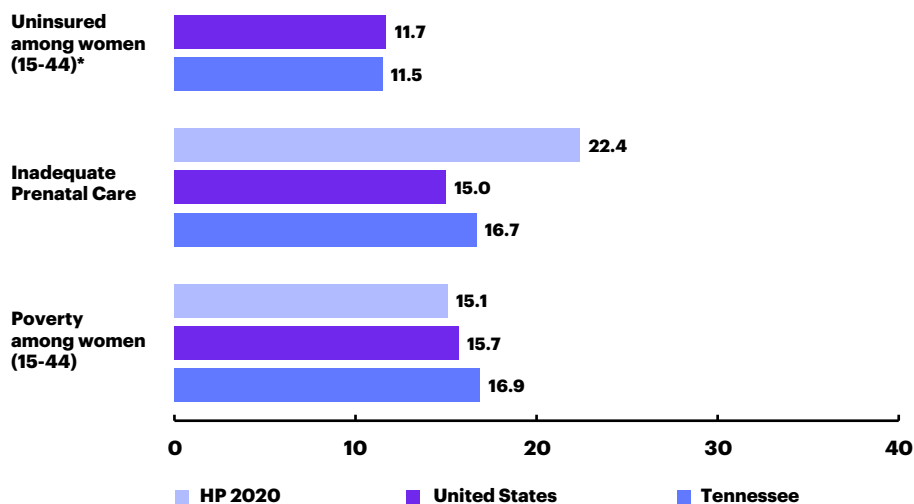
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TENNESSEE MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$57
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$11.80
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

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2019
MARCH OF DIMES
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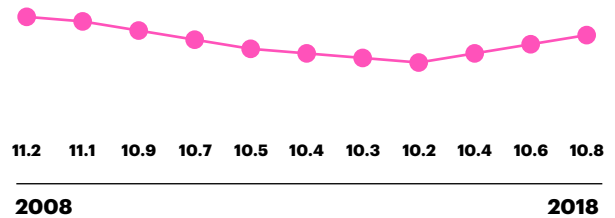
TEXAS

PREMATURITY
GRADE

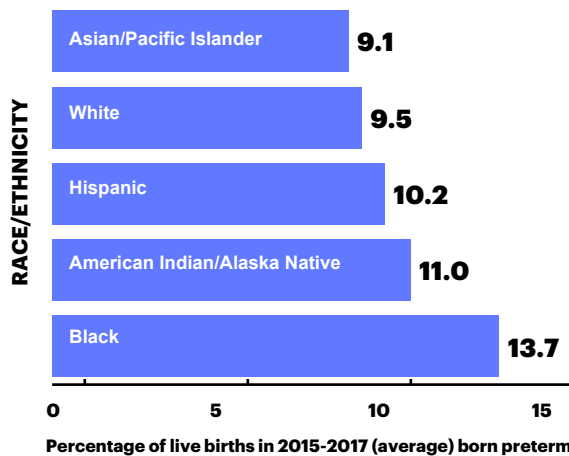
D

PRETERM
BIRTH RATE

10.8%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Texas, the preterm birth rate among black women is 38% higher than the rate among all other women.

DISPARITY RATIO:

1.03

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Bexar	F	11.8%	Worsened
Dallas	C	9.9%	Worsened
Harris	D	11.1%	Improved
Hidalgo	F	12.8%	Worsened
Tarrant	C	9.7%	Improved
Travis	B-	9.0%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Houston	D-	11.2%	Worsened

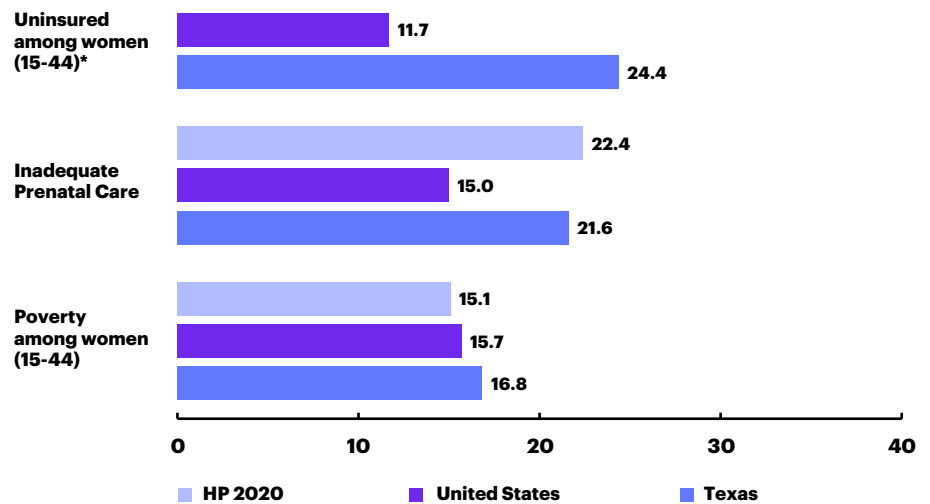
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TEXAS MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$62
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$34.48
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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NOT ADOPTED

MEDICAID EXPANSION

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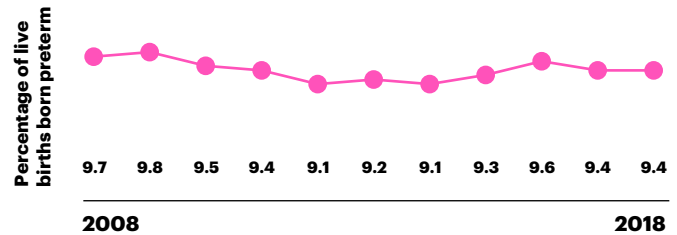
UTAH

PREMATURITY
GRADE

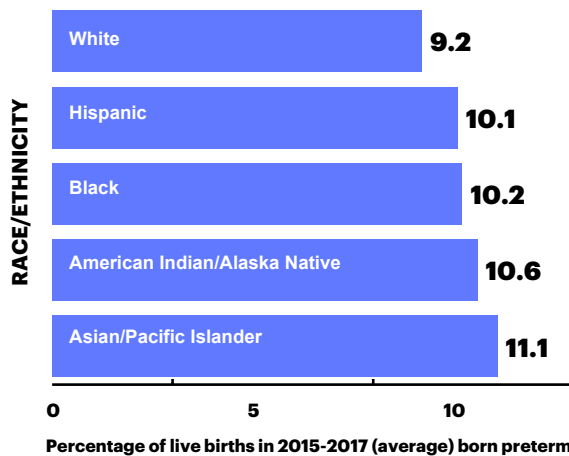
C+

PRETERM
BIRTH RATE

9.4%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Utah, the preterm birth rate among Asian/Pacific Islander women is 19% higher than the rate among all other women.

DISPARITY RATIO:

1.15

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Cache	C+	9.5%	Improved
Davis	C-	10.1%	Worsened
Salt Lake	C+	9.5%	Worsened
Utah	B-	9.1%	No change
Washington	B	8.8%	Improved
Weber	C+	9.5%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Salt Lake City	C+	9.3%	Worsened

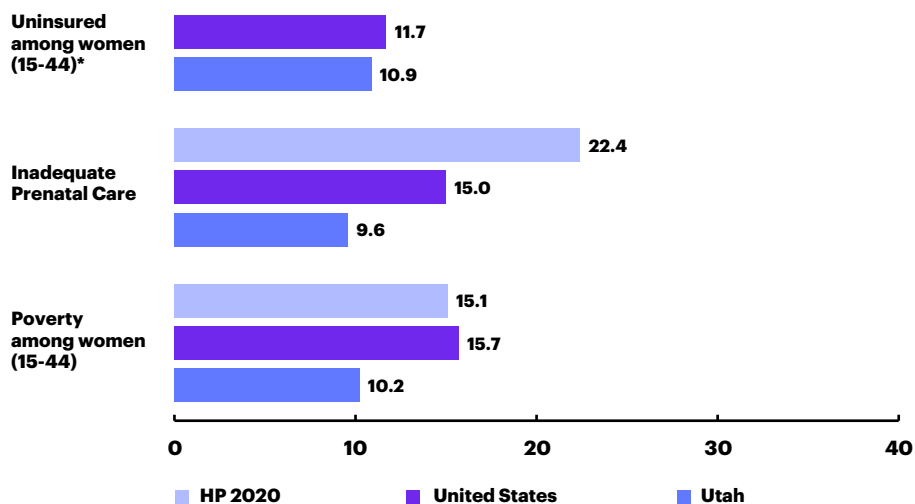
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UTAH MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$56
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$6.16
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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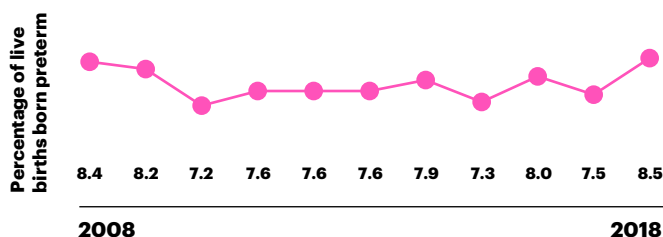
VERMONT

PREMATURITY
GRADE

B+

PRETERM
BIRTH RATE

8.5%



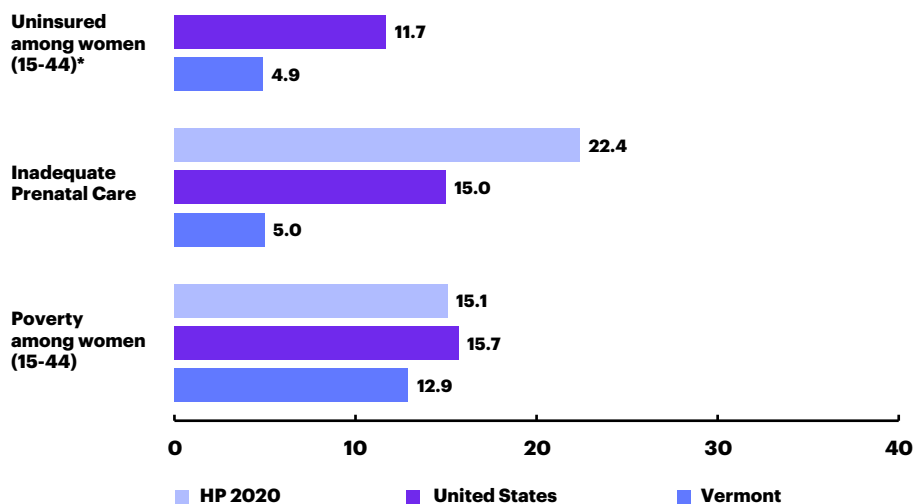
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chittenden	A	7.2%	Improved
Franklin	A	6.4%	Improved
Rutland	A	6.3%	Improved
Washington	A	7.4%	Improved
Windham	A	6.6%	Improved
Windsor	B	8.8%	Worsened

VERMONT MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$1.63
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

MEDICAID EXPANSION

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OTHER RECOMMENDED STATE ACTIONS

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2019
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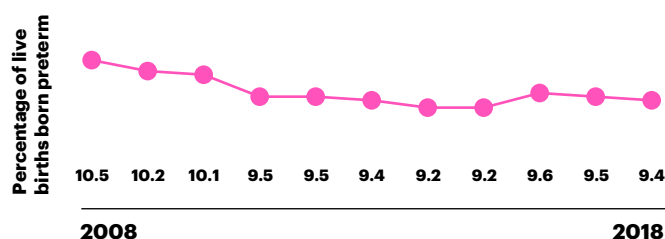
VIRGINIA

PREMATURITY
GRADE

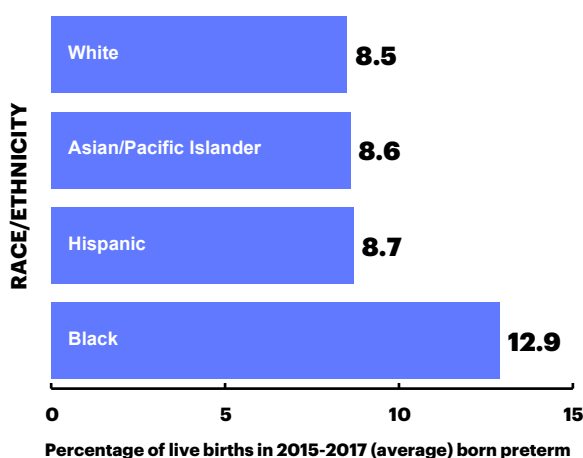
C+

PRETERM
BIRTH RATE

9.4%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Virginia, the preterm birth rate among black women is 52% higher than the rate among all other women.

DISPARITY RATIO:

1.15

CHANGE FROM BASELINE:
No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Chesterfield	C	9.9%	Worsened
Fairfax	C+	9.3%	Worsened
Henrico	C+	9.6%	Improved
Loudoun	B	8.7%	Worsened
Prince William	C+	9.4%	Worsened
Virginia Beach (city)	C+	9.3%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Virginia Beach	C+	9.3%	Improved

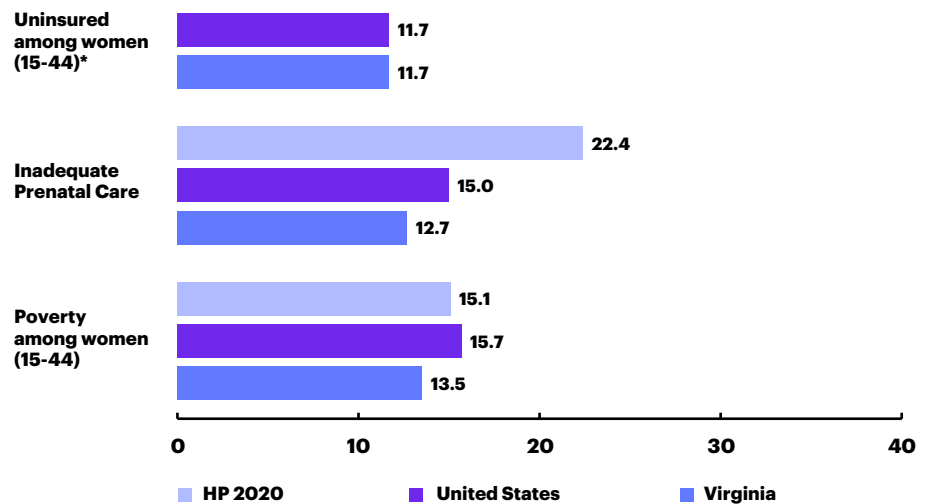
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VIRGINIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$12.28
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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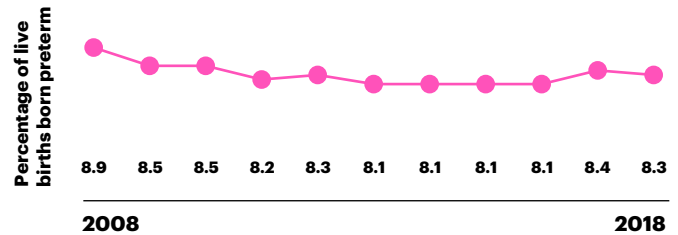
WASHINGTON

PREMATURITY
GRADE

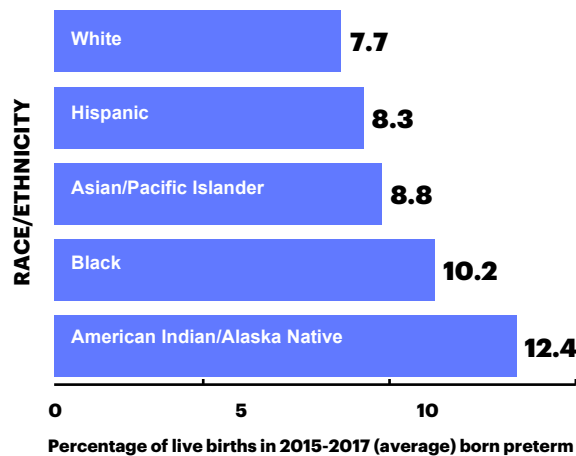
B+

PRETERM
BIRTH RATE

8.3%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Washington, the preterm birth rate among American Indian/Alaska Native women is 53% higher than the rate among all other women.

DISPARITY RATIO:

1.28

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

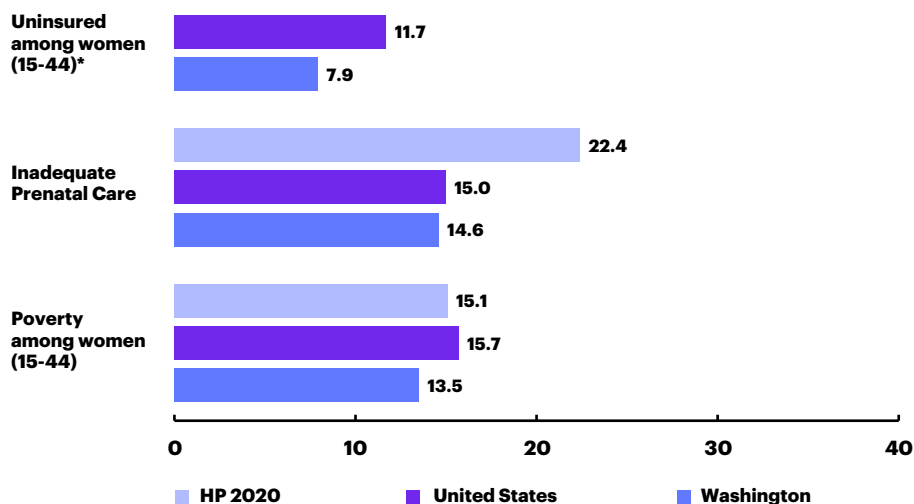
COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Clark	B	8.7%	Worsened
King	A-	8.1%	Worsened
Pierce	B-	9.2%	Worsened
Snohomish	A-	8.1%	Worsened
Spokane	B	8.7%	Improved
Yakima	B+	8.2%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Seattle	A-	8.1%	Worsened

WASHINGTON MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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*The Healthy People 2020 goal is for all women (15-44) to be insured.

**\$64
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

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**\$8.89
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

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ADOPTED

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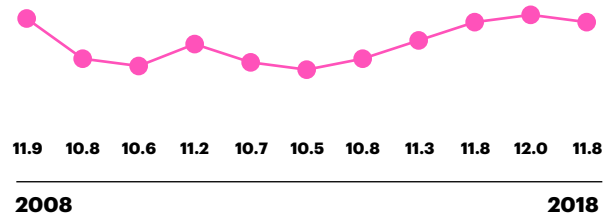
WEST VIRGINIA

PREMATURITY
GRADE

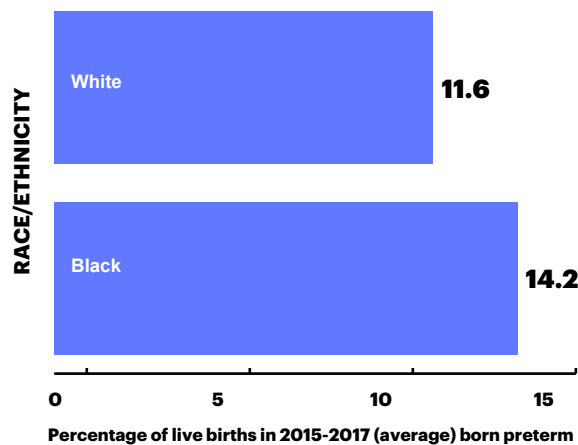
F

PRETERM
BIRTH RATE

11.8%

Percentage of live
births born pretermPRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In West Virginia, the preterm birth rate among black women is 22% higher than the rate among all other women.

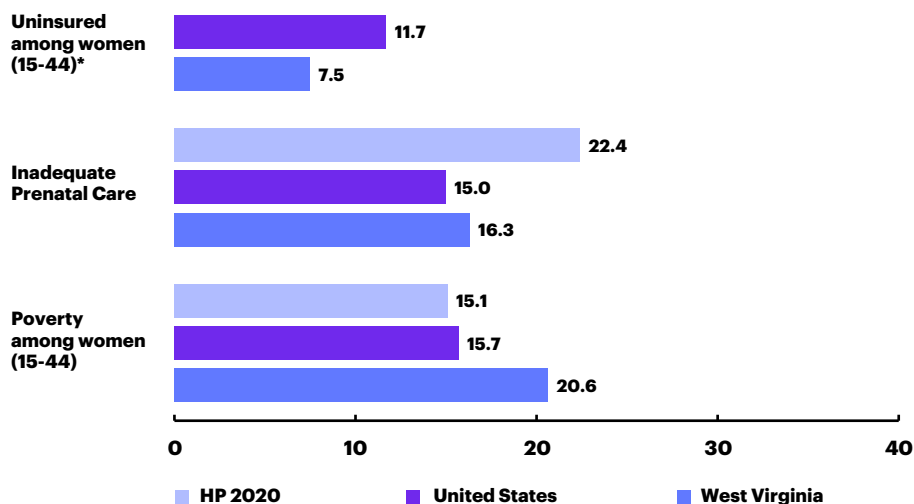
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Berkeley	D-	11.2%	Worsened
Cabell	F	14.9%	Worsened
Kanawha	F	15.0%	Worsened
Monongalia	C+	9.4%	Improved
Raleigh	F	12.8%	Worsened
Wood	F	13.8%	Worsened

WEST VIRGINIA MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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\$52 THOUSAND

AVERAGE COST OF A PRETERM BIRTH

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\$6.11 MILLION

MATERNAL AND CHILD HEALTH BLOCK GRANT

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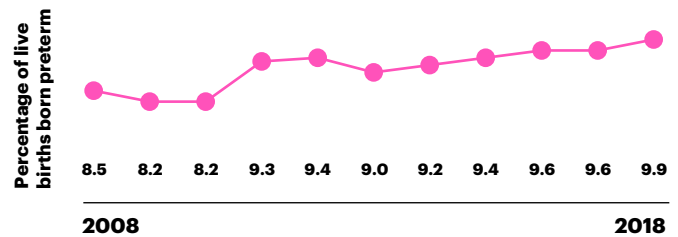
WISCONSIN

PREMATURITY
GRADE

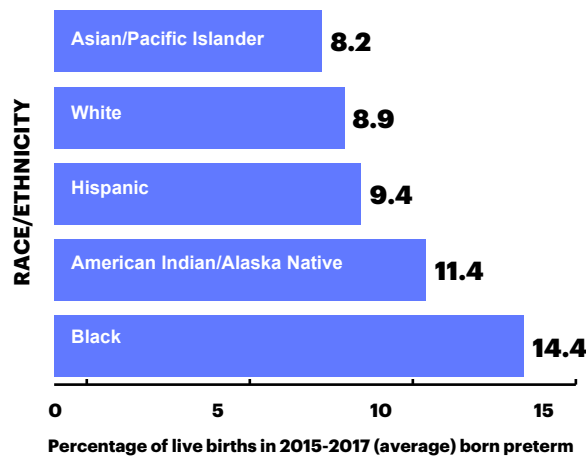
C

PRETERM
BIRTH RATE

9.9%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Wisconsin, the preterm birth rate among black women is 62% higher than the rate among all other women.

DISPARITY RATIO:

1.34

CHANGE FROM BASELINE:

No Improvement

PRETERM BIRTH RATES BY COUNTIES AND CITY

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Brown	C+	9.5%	Improved
Dane	B-	9.0%	Worsened
Milwaukee	F	11.6%	Worsened
Outagamie	C	9.7%	No change
Racine	D-	11.2%	No change
Waukesha	B+	8.5%	Improved

CITY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Milwaukee	F	12.8%	Worsened

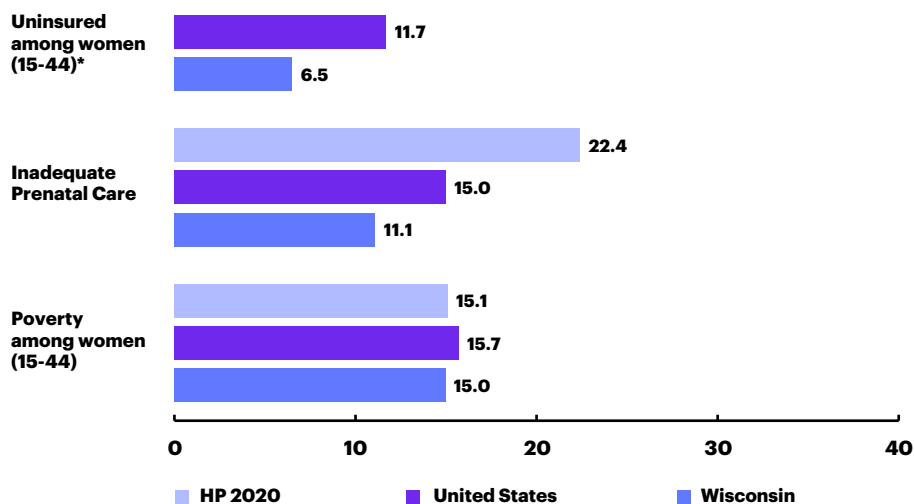
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WISCONSIN MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

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\$61 THOUSAND

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\$10.80 MILLION

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NOT ADOPTED

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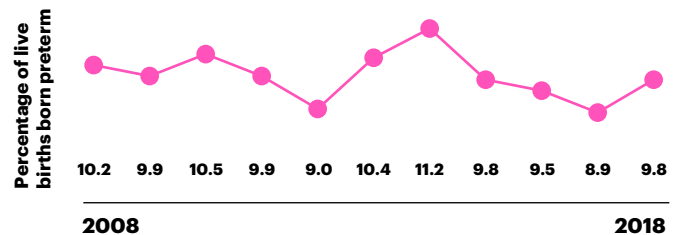
WYOMING

PREMATURITY
GRADE

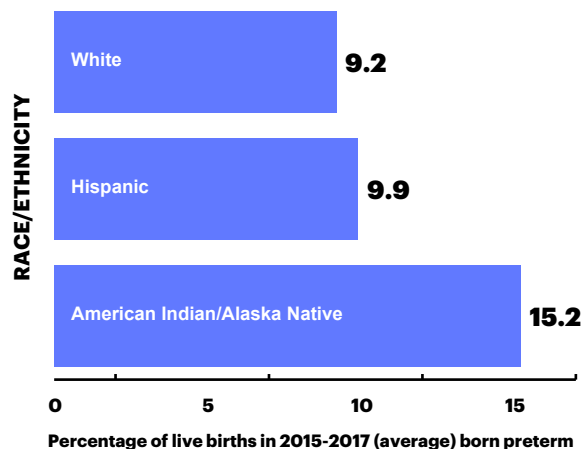
C

PRETERM
BIRTH RATE

9.8%

PRETERM BIRTH
RATE BY RACE
AND ETHNICITY

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In Wyoming, the preterm birth rate among American Indian/Alaska Native women is 63% higher than the rate among all other women.

DISPARITY RATIO:

1.36

CHANGE FROM BASELINE:

No Improvement

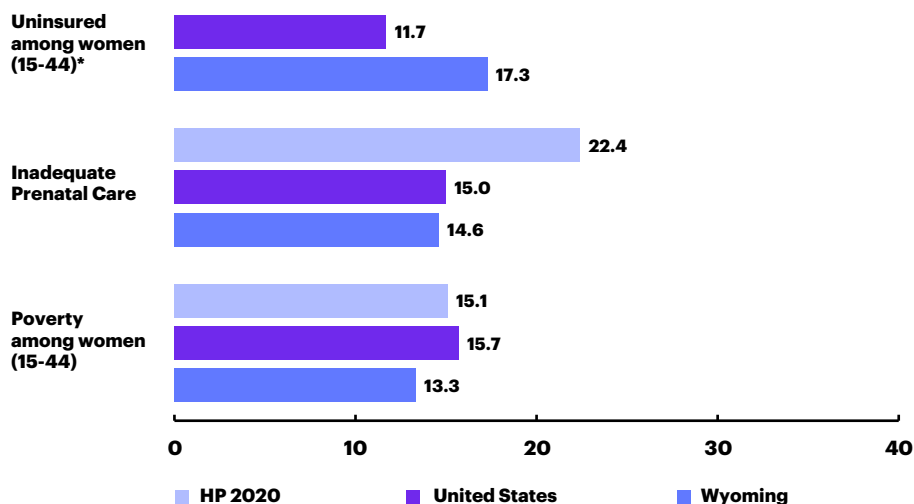
PRETERM BIRTH RATES BY COUNTIES

COUNTY	GRADE	PRETERM BIRTH RATE	CHANGE IN RATE FROM LAST YEAR
Albany	A	5.9%	Improved
Campbell	C	9.7%	Improved
Fremont	C+	9.6%	Improved
Laramie	A-	7.9%	Improved
Natrona	D	10.9%	Worsened
Sweetwater	C+	9.3%	Worsened

WYOMING MATERNAL AND INFANT HEALTH: CONTEXT AND ACTIONS

SELECTED SOCIAL DETERMINANTS OF HEALTH

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**\$65
THOUSAND**

AVERAGE COST OF A PRETERM BIRTH

The estimated societal cost per preterm birth includes medical care for premature children, maternal delivery costs, early intervention services, special education services and lost productivity. State estimates reflect 2016 adjustments to underlying national estimates developed in 2005 (see technical notes for additional details). Adjustments per state include birth and infant mortality rate and incidence by gestational age, service bundle composition and costs and cost inflation.

**\$1.08
MILLION**

MATERNAL AND CHILD HEALTH BLOCK GRANT

The Maternal and Child Health (MCH) Block Grant is one source of federal support for states to improve the health of moms and children. States have some flexibility in allocating funds, which can be used to increase access to quality health care for pregnant women. State MCH block grant amounts provide an example of the limited amount of available funds in comparison to the costs of prematurity and other complications.

NOT ADOPTED

MEDICAID EXPANSION

Medicaid expansion to cover individuals up to 138% of the federal poverty level can play an essential role in improving maternal and infant health. A growing number of studies indicate that Medicaid expansion has reduced the rate of women of childbearing age who are uninsured, improved health outcomes and helped to reduce disparities, including lower rates of premature birth and low birthweight for Black infants in expansion states.

OTHER RECOMMENDED STATE ACTIONS

March of Dimes recommends **key policy actions** to improve maternal and infant health in all states. Future Report Cards will assess these actions at the state level.

- **COMPREHENSIVE MEDICAID COVERAGE EXTENSION FOR ALL WOMEN TO AT LEAST ONE YEAR POSTPARTUM** In too many states, Medicaid maternity coverage ends 60 days after giving birth, ending access to care at a time when risks of maternal complications and death persist.
- **GROUP PRENATAL CARE ENHANCED REIMBURSEMENT** Group prenatal care has shown significant benefits to maternal health, increases healthy behaviors and reduces adverse birth outcomes. Increased benefits were seen in Black women who participated in group prenatal care. Enhanced reimbursement models, including delivery and outcomes-based incentives, can encourage providers to offer it.
- **MATERNAL MORTALITY REVIEW COMMITTEES** Establishment, funding and reporting of state data to CDC through Maternal Mortality Review Committees is essential to understanding and addressing the causes of maternal death.

MORE INFORMATION [MARCHOFDIMES.ORG/REPORTCARD](https://www.marchofdimes.org/reportcard)

For details on data sources and calculations, see Technical Notes. For more information on how we are working to reduce premature birth, visit www.marchofdimes.org.

2019 MARCH OF DIMES REPORT CARD

TECHNICAL NOTES

PREMATURE BIRTH: DEFINITION AND SOURCE

Premature or preterm birth is a birth with less than 37 weeks gestation based on the obstetric estimate of gestational age. Data used in this report card came from the National Center for Health Statistics (NCHS) natality files, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.¹ This national data source was used so that data are comparable for each state and jurisdiction-specific report card. Data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies due to timing of data submission and handling of missing data. The preterm birth rates shown at the top of report card was calculated from the NCHS 2018 final natality data. Preterm birth rates in the trend graph are from the NCHS 2008-2018 final natality data. County preterm birth rates are from the NCHS 2017 final natality data. Preterm birth rates for bridged racial and ethnic categories were calculated from NCHS 2015-2017 final natality data. Preterm birth rates were calculated as the number of premature births divided by the number of live births with known gestational age multiplied by 100.

GRADING METHODOLOGY

Expanded grade ranges were introduced in 2019. Grade ranges remain based on standard deviations of final 2014 state and District of Columbia preterm birth rates away from the March of Dimes goal of 8.1 percent by 2020. Grades were determined using the following scoring formula: (preterm birth rate of each jurisdiction – 8.1 percent) / standard deviation of final 2014 state and District of Columbia preterm birth rates. Each score within a grade was divided into thirds to create +/- intervals. The resulting scores were rounded to one decimal place and assigned a grade. See the table for details.

PREMATURE BIRTH BY COUNTY

Report cards for states and jurisdictions, except District of Columbia, display up to 6 counties with the greatest number of live births. Counties are not displayed if the number of premature births is less than 20. Counties are ordered alphabetically. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2017 county preterm birth rate to the 2016 rate.

PREMATURE BIRTH BY CITY

Report cards for states and jurisdictions, except District of Columbia, display the city with the greatest number of live births. Cities are not displayed for Connecticut, Delaware, Maine, Vermont, West Virginia and Wyoming due to limited availability of data. Grades were assigned based on the grading criteria described above. Change from previous year was calculated by comparing the 2017 city preterm birth rate to the 2016 rate.

PREMATURE BIRTH BY RACE/ETHNICITY OF THE MOTHER

Mother's race and Hispanic ethnicity are reported separately on birth certificates. Rates for Hispanic women include all bridged racial categories (white, black, American Indian/Alaska Native and Asian/Pacific Islander). Rates for non-Hispanic women are classified according to race. The Asian/Pacific Islander category includes Native Hawaiian. To provide stable rates, racial and ethnic groups are shown on the report card if the group had 20 or more premature births in each year from 2015-2017. To calculate preterm birth rates on the report card, three years of data were aggregated (2015-2017). Preterm birth rates for not stated/unknown race are not shown on the report card.

PREMATURE BIRTH DISPARITY MEASURES

The March of Dimes disparity ratio is based on Healthy People 2020 methodology and provides a measure of the differences, or disparities, in preterm birth rates across racial/ethnic groups within a geographic area.² The disparity ratio compares the racial/ethnic group with the lowest preterm birth rate (comparison group) to the average of the preterm birth rate for all other groups.

To calculate the disparity ratio, the 2015-2017 preterm birth rates for all groups (excluding the comparison group) were averaged and divided by the 2015-2017 comparison group preterm birth rate. The comparison group is the racial/ethnic group with the lowest six-year aggregate preterm birth rate (2010-2015) among groups that had 20 or more premature births in each year from 2010-2015. A disparity ratio was calculated for U.S. states, the District of Columbia and the total U.S. A disparity ratio was not calculated for Maine, Puerto Rico, Vermont and West Virginia due to limited availability of data. A lower disparity ratio is better, with a disparity ratio of 1 indicating no disparity.

GRADE	PRETERM BIRTH RATE RANGE SCORING CRITERIA
A	Preterm birth rate less than or equal to 7.7 percent
A-	Preterm birth rate of 7.8 percent to 8.1 percent
B+	Preterm birth rate of 8.2 percent to 8.5 percent
B	Preterm birth rate of 8.6 percent to 8.9 percent
B-	Preterm birth rate of 9.0 percent to 9.2 percent
C+	Preterm birth rate of 9.3 percent to 9.6 percent
C	Preterm birth rate of 9.7 percent to 10.0 percent
C-	Preterm birth rate of 10.1 percent to 10.3 percent
D+	Preterm birth rate of 10.4 percent to 10.7 percent
D	Preterm birth rate of 10.8 percent to 11.1 percent
D-	Preterm birth rate of 11.2 percent to 11.4 percent
F	Preterm birth rate greater than or equal to 11.5 percent

PREMATURE BIRTH DISPARITY MEASURES

Progress toward eliminating racial and ethnic disparities was evaluated by comparing the 2015-2017 disparity ratio to a baseline (2010-2012) disparity ratio. Change between time periods was assessed for statistical significance at the 0.05 level using the approach recommended by Healthy People 2020.² If the disparity ratio significantly improved because the average preterm birth rate for all other groups got better, we displayed "Improved" on the report card. If the disparity ratio significantly worsened because the lowest group got better or the average of all other groups got worse, we displayed "Worsened" on the report card. If the disparity ratio did not significantly change, we displayed "No Improvement" on the report card.

The report card also provides the percent difference between the racial/ethnic group with the 2015-2017 highest preterm birth rate compared to the combined 2015-2017 preterm birth rate among women in all other racial/ethnic groups. This percent difference was calculated using only the racial/ethnic groups displayed on the state or jurisdiction-specific report card. This difference was calculated for each U.S. state with adequate numbers and the District of Columbia.

SELECTED SOCIAL DETERMINANTS OF HEALTH

March of Dimes recognizes the importance of certain risk factors that are associated with premature birth. Three of these contributing factors are highlighted for each state. These risk factors are poverty in women (age 15-44 years), lack of health insurance in women (15-44 years) and inadequacy of prenatal care.

A woman was considered uninsured if she was not covered by any type of health insurance.³ The uninsured percent is calculated among women ages 15-44. Persons in poverty are defined as those who make less than 100% of the poverty threshold established by the US Census Bureau.⁴ The Federal poverty threshold for a family of three was \$19,749 in 2017. Poverty is reported for women 15-44 years. Adequacy of prenatal care is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate and adequate plus) by combining information about the timing of prenatal care, the number of visits and the infant's gestational age.⁵

FINANCIAL AND ECONOMIC INDICATORS

Estimates of the national societal economic burden of preterm birth in 2005 generated for the Institute of Medicine's (IOM) report⁶, Preterm Birth: Causes, Consequences and Prevention served as the foundation for updating costs to 2016 and for providing separate estimates for each state and the District of Columbia (see https://marchofdimes.org/peristats/documents/Cost_of_Prematurity_2019.pdf for details)⁷. Costs were updated adjusting for price changes over time and for variation in prices of services between states. Changes in the rate of preterm birth, the distribution of preterm birth by gestational age (GA), and the rate of infant mortality by GA at the national and state levels were also incorporated. This cost of preterm birth estimates are the most comprehensive national estimates to date, and provide the first profile of such costs by state for every state and the District of Columbia.

Medicaid expansion is provided as not adopted, adopted and adopted but not implemented. Medicaid expansion has reduced the rates of uninsured. Increased access and utilization of health care are significantly associated with Medicaid expansion.⁸

Maternal and child block grant totals are available from Fiscal Year 2019 for each state. The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is a federal program devoted to improving the health of all women, children and families. Title V provides funding to state maternal and child health (MCH) programs, which serve 76 million people in the U.S.⁹ Maternal and child (MCH) block grants are a key federal source of support for states to improve the health of moms and babies. Other funding sources and strategies are also available to states to make an impact on prematurity.

CALCULATIONS

All natality calculations were conducted by the March of Dimes Perinatal Data Center. Calculations for the cost of premature birth were conducted by the University of Utah.

REFERENCES

¹ National Center for Health Statistics, final natality data 2015-2018.

² Talih M, Huang DT. Measuring progress toward target attainment and the elimination of health disparities in Healthy People 2020. Healthy People Statistical Notes, no 27. Hyattsville, MD: National Center for Health Statistics. 2016.

³ IPUMS-USA, University of Minnesota, ipums.org. American Community Survey, US Census Bureau.

⁴ PUMS-CPS, University of Minnesota, ipums.org. Current Population Survey, US Census Bureau.

⁵ Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a Proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994; 84: 1414-1420.

⁶ Behrman RE, Stith Butler A, eds. Institute of Medicine, Committee on Understanding Preterm Birth and Assuring Healthy Outcomes. Preterm Birth: Causes, Consequences, and Prevention. Washington, DC: The National Academies Press; 2007.

⁷ Waitzman NJ and Jalali A. Updating National Preterm Birth Costs to 2016 with Separate Estimates for Individual States. Salt Lake City, UT: University of Utah; 2019.

⁸ Kaiser Family Foundation, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>. Retrieved on June 30, 2019.

⁹ Health Resources and Services Administration. Title V Maternal and Child Block Grant Program. Available at: <https://mchb.hrsa.gov/data-research-epidemiology>. Retrieved on September 12, 2019.

STATE SPOTLIGHTS

SUMMARY STATEMENT

Through collaboration and partnerships, The California Department of Public Health, Maternal Child and Adolescent Health Division (CDPH/MCAH) has been working to turn the curve on the State's prematurity rate by tackling disparities in preterm births. In 2017, the Black preterm birth rate was 1.7 times more than the White preterm birth rate. Multiple focused initiatives launched in counties with the highest number of Black preterm births have been sparked to address inequity in birth outcomes.

ACTIVITIES AND RESULTS

In collaboration with 14 Local Health Jurisdictions (which represent over 90 percent of all Black births in the State,) CDPH/MCAH leads and funds the implementation of the Black Infant Health Program (BIH) to improve Black birth outcomes. BIH focuses its implementation strategy on the key contributing factors of disparities, namely the toxic stress of chronic racism. Participants learn proven strategies to reduce stress and develop life skills through a group-based approach with complementary case management. MCAH has observed improvements in the Black preterm birth rate between 2007 and 2017 in eight counties currently implementing BIH. In addition, through a legislative proposal brought to fruition in 2018 by March of Dimes and other California stakeholders, CDPH/MCAH has established the Perinatal Equity Initiative (PEI) with \$8 million State General Funds to complement the BIH program. In partnership with the March of Dimes, CDPH/MCAH continues to lead the Community Birth Plan initiative that unites hospitals in Los Angeles with high Black prematurity rates and the Black communities delivering at these hospitals. The goal is to unite the community and hospitals around the problem and evidence-based interventions that can reduce prematurity.

The Maternal and Infant Health Assessment (MIHA) survey, implemented by the MCAH Division provides insights on the relationship between maternal experiences and birth outcomes to help guide programs. MIHA data reveal a sharp increase in chronic worry about racial discrimination among Black women. In 2017, nearly two-thirds of Black women worried often about experiencing racial discrimination for themselves or a loved one, and seven in 10 Black women experienced incidents of racial discrimination. Worry about racial discrimination has been linked to preterm birth, maternal hypertension and symptoms of maternal depression.

The 2018-20 California Preconception CoIIN, led by CDPH/MCAH, March of Dimes, and other state preconception health experts, aims to improve the preconception health status of women of reproductive age, particularly low-income women and women of color.

CONNECTICUT

SUMMARY STATEMENT

Unplanned pregnancies and poor preconception health increase the risk for adverse outcomes, including preterm birth. Optimizing a woman's health before pregnancy and increasing birth intentionality and spacing is essential to improving maternal and infant outcomes, as well as reducing disparities in these outcomes. The Connecticut Department of Public Health (DPH), in collaboration with the CT MCH Coalition and March of Dimes CT Chapter, is engaged in an initiative called Every Woman Connecticut (EWCT). This initiative is a learning collaborative that seeks to promote pre- and interconception health care as an integral part of routine care within both clinical and community-based settings. EWCT is utilizing the One Key Question (OKQ) screening tool in communities with high volume/burden of poor birth outcomes and among communities expressing interest and readiness.

ACTIVITIES AND RESULTS

The EWCT Learning Collaborative is made up of clinical and community-based partners who serve women of childbearing ages across Connecticut. Communities with high volume/high burden of poor birth outcomes were sought for their participation in EWCT, as well as their level of expressed interest and readiness. The main goal of EWCT is to increase expertise and self-efficacy in implementing routine pregnancy intention screening and appropriate care, education, and services to ultimately improve birth spacing, increase pregnancy intentionality, and the proportion of Connecticut women who deliver a live birth who report discussing pre- and interconception health with a healthcare worker. An estimated total of 326 of providers from 39 cities/towns, as well as from 9 statewide programs, have been involved with the initiative since its inception in May 2016. The EWCT Learning Collaborative is planning activities to strengthen the existing participating communities, by adding additional partners and providing more technical support. A multi-stage collective impact evaluation of the EWCT/OKQ initiative will begin in late 2019 and will examine both process and outcomes of the initiative.

The EWCT Advisory Committee also convened a workgroup focusing on increasing access to contraception, a continuation of efforts that were started under the ASTHO IAC project. The workgroup, co-chaired by March of Dimes and the Connecticut Maternal and Child Health Coalition, has representation from DPH, Department of Social Services (Medicaid), Department of Mental Health and Addiction Services (DMHAS), Ct Office of Early Childhood (OEC), ACOG, Community Health Centers, Inc., Planned Parenthood of Southern New England, and other valued organizational members. Through this workgroup, EWCT is identifying and addressing system barriers that limit the uptake of comprehensive contraceptive care for Connecticut people of childbearing ages who wish to avoid or delay a pregnancy.

SUMMARY STATEMENT

In 2014, Upstream USA met with then Delaware Governor Jack Markell to discuss the state's participation in a statewide initiative to reduce unintended pregnancy in Delaware. This initiative would later be named Delaware Contraceptive Access Now (Delaware CAN). Around the same time, the Governor-appointed Delaware Healthy Mother and Infant Consortium (DHMIC) had identified the reduction of unintended pregnancies as one of its strategic priorities to reduce infant mortality and improve birth outcomes.

The Delaware CAN initiative started as a public-private partnership between the State of Delaware and Upstream USA. Delaware CAN includes a set of policy changes focused on reducing unintended pregnancies and improving access to the full range of contraception, including long-acting reversible contraceptives (LARCs). The goal is to ensure all women of reproductive age in Delaware, regardless of insurance or ability to pay, have same-day access to the full range of contraceptive methods at low or no cost. This initiative was designed to remove barriers related to cost, education, and access to contraceptives by implementing policy changes, providing trainings and technical assistance to clinical sites, and developing a statewide public awareness campaign. Delaware CAN is supported by a combination of private individuals and foundations, as well as state investments. The privately funded total budget for the five-year initiative is approximately \$20 million. Current Delaware Governor John Carney recommended that the Fiscal Year 2020 budget for the state Division of Public Health (DPH) include \$1.5 million to sustain ongoing statewide support for Delaware CAN. The funding was approved and the program will be administered by DPH's Family Health Systems Section. DPH will provide funding to purchase contraceptive methods for individuals who are uninsured or underinsured through the Title X Family Planning network of providers and in the hospital setting for Immediate Post-Partum (IPP) contraception.

ACTIVITIES AND RESULTS

Much of the foundation to implement Delaware CAN was laid in 2015. In January, the Delaware Division of Medicaid and Medical Assistance (DMMA) began allowing separate reimbursement for LARC devices via the Medicaid pharmacy benefit, when occurring concurrently with childbirth-related services. This enabled hospitals to provide LARC placement and be reimbursed for the device for Medicaid patients IPP, (after childbirth but before hospital discharge). Starting May 2015, DPH made public funding available to purchase LARC devices. Some funding was provided directly to Title X agencies to purchase LARCs while the rest was used to purchase LARC stock for the State Pharmacy. In January 2016, former Delaware Governor Jack Markell formally announced the launch of Delaware CAN, which included private funding from individual philanthropists and foundations, as well as funding from the Delaware DPH. In June 2016, DPH provided additional funding to purchase more LARC stock for the State Pharmacy. In June 2017, a Delaware Medicaid State Plan Amendment (17-003) was approved and retroactively effective from January 2, 2017 to provide a mechanism for federally qualified health centers (FQHCs) in Delaware to obtain compensation for LARCs. This allowed FQHCs to maintain adequate stock of LARCs, and replaced the need for direct state purchase of devices.

Upstream USA launched the public awareness campaign, "Be Your Own Baby" in spring 2017. The target demographic for the campaign, which ran through fall 2018, was Delaware women ages 18-29. Campaign messaging was informed by focus groups and survey responses, and focused on access to "free" birth control. Messages were designed to be "fun" and "empowering." Central message formats included a professionally produced music video hosted on YouTube, online streaming music advertisements, social media posts and online advertising. The call to action for all messaging was to visit the Be Your Own Baby website, beyourownbaby.org, where visitors could find nearby clinic locations that provide free same-day contraceptive services. Three sites from a large family planning outpatient clinic enabled online scheduling through the website. Website visitors could also submit reimbursement for transportation to a clinic or for any out-of-pocket contraceptive costs. The website provided information about different contraceptive method types and linked to Bedsider.org for more information.

Currently, Delaware CAN is focused on sustainability. Upstream is working with DE CAN partners to ensure that key elements are in place including stocking methods, patient educational materials, optimal billing and coding practices, policies and procedures and training maintenance plans etc. Upstream has a plethora of web-based materials and resources including e-learning courses on patient centered contraceptive counseling and billing/coding for contraception.

The University of Maryland and the University of Delaware were independently contracted to conduct a robust evaluation of the DECAN intervention and to study the ways in which the initiative may have changed access to LARCs and other family planning services in the state of Delaware, if it improved clinical outcomes and if the program reduced unintended pregnancies over time for women of childbearing age. They will follow the sustainability program over the next five years.

Child Trends, a research organization focused on improving the lives of children and youth, performed an evaluation and issued a report using available contraceptive data from 2014 to 2017 in Delaware among Delaware Title X family planning clients ages 20–39. The observed movement from moderately effective contraception to highly effective long acting reversible contraception paired with a small decrease in no method, was linked to a substantial simulated decrease (24.2 percent) in the unintended pregnancy rate among this population. The complete report, including methodology and limitations, was commissioned by Upstream and can be found at [ChildTrends.org](https://www.childtrends.org).

SUMMARY STATEMENT

Evidence-based Home Visiting

The Maternal, Infant, Early Childhood Home Visiting (MIECHV) program is a federal initiative dedicated to expansion of access to voluntary evidence-based home visiting in the US and tribal communities and territories. The Georgia Department of Public Health (DPH) oversees administration of Georgia's MIECHV program and partners with 15 Local Implementing Agencies (LIAs). In addition to the 15 MIECHV LIAs, DPH has expanded home visiting to 6 different agencies. These LIAs utilize one of the following Evidenced-Based Home Visiting (EBHV) models: (1). Early Head Start-Home Visiting (EHS-HV), (2) Healthy Families Georgia (HFG), (3) Parents as Teachers (PAT) and (4) Nurse-Family Partnership (NFP). Decades of scientific research show that home visits during pregnancy and early childhood improve the lives of children and families, and can be cost-effective in the long term, with the largest benefits coming through decreasing families' need for public assistance programs and increased individual earnings.

Group Prenatal Care

CenteringPregnancy® has been implemented in three public health locations with high numbers of preterm births.

Family Planning

DPH launched a campaign to increase access to long acting reversible contraceptive devices (LARCs) for women who chose to space or delay pregnancy.

ACTIVITIES AND RESULTS

Evidence-based Home Visiting

The Georgia EBHV system includes identification, referral, screening, parent education, and linkage to appropriate community services. Georgia has a proven track record of implementing quality EBHV programs throughout the state and between the periods of October 1, 2017 to September 30, 2018, certified home visitors completed 24,042 visits to at-risk families and 5,946 community referrals. In order to measure program's performance, provide continuous quality improvement, and evaluation, Georgia collects data on 19 performance measures. The performance measures reflect a two-generation approach aimed at improving the well-being of both parents and children across the lifespan. The performance measures are intended to help tell the story of home visiting in Georgia and demonstrate the impact of the program on parents and their children. For example in FY 2018 (10/1/17 to 9/30/18):

Depression Screening: 80% of Georgia MIECHV caregivers were screened for depression.

Developmental Screening: 67% of children enrolled in Georgia MIECHV had a timely screening for developmental delays.

Intimate Partner Violence (IPV) Screening: 79% of MIECHV caregivers were screened for IPV.

Families are linked to other community services based upon the results of the assessments and screenings.

Additionally:

9% of women enrolled prenatally delivered preterm.

38% of mothers were breastfeeding their child at 6 months.

81% of children received their last well child visit.

76% of mothers received a postpartum visit within 8 weeks of delivery.

93% of primary caregivers who used tobacco products at enrollment received a referral to cessation services.

80% of primary caregivers consistently practiced safe sleep methods with their infants.

Of all households served:

1% had an investigated case of maltreatment following enrollment.

3% had an injury related emergency department visit.

The Georgia Department of Public Health is committed to providing a quality comprehensive community-based Maternal and Early Childhood system which includes evidenced-based home visiting services as a major strategy to improve the well-being of mothers, children and families which will ultimately ensure thriving communities in rural and urban areas alike.

Group Prenatal Care

State funding was allocated to expand Medicaid reimbursement of group prenatal care in 2018. A reimbursement pilot is underway in four CenteringPregnancy® locations in the state including one in a public health setting. Successful results from the pilot and full state rollout of expanded reimbursement will increase sustainability and access to group prenatal care and a decrease in preterm births.

Family Planning

The campaign included a media awareness component and increased the number of midlevel providers and LARC inventory in public health clinics. Since the launch of the campaign in 2015, nearly 30,000 LARCs have been provided resulting in an increase of 67%.

SUMMARY STATEMENT

Louisiana has worked tirelessly for several years to reduce pre-term births and infant mortality through focused interventions, Medicaid reforms, education, and increased access to reproductive health services, sexually transmitted infection (STI) prevention, testing and treatment and smoking cessation for Louisiana residents of child-bearing age. Addressing health disparities like those seen in our premature birth report card requires a long-term commitment with multiple partners to implement effective changes. We still have a long way to go, but we are confident that by continuing to work together with health care providers, community leaders and individual Louisiana residents, we can change the future of our children's health.

ACTIVITIES AND RESULTS

In recent years, there has been a significant push through federal funding and with Medicaid Expansion to increase access to family planning and STI services. More consistent health coverage for women across the life span – preconception, post-partum, and interconception periods improves maternal health. Reducing the number of Louisiana babies born to mothers with STIs helps reduce premature births, and reducing preterm births reduces the number of days babies spend in neonatal intensive care units and improves infant health trajectories. Medicaid now covers all FDA-approved contraceptive methods, including long-acting, reversible contraceptives (LARC), which is critical to improving birth spacing and reducing the 60% of unintended pregnancies in Louisiana, both of which contribute to poor birth outcomes. For decades OPH Parish Health Units (PHU) – funded by Title X and the state – have been a critical safety net for these services. Medicaid Expansion has increased access to these services for all, both in and outside of the PHUs.

In addition to Medicaid expansion, the Louisiana Department of Health (LDH) has partnered on several additional activities to improve birth outcomes. Since 2014, LDH, Medicaid, and all Louisiana hospitals have committed to curb the practice of early inductions and Cesarean Sections, implement extensive birth outcomes quality metrics for Medicaid managed care organizations, and introduce payment reform. LDH is also working in partnership with the March of Dimes (MoD), Medicaid, and the Louisiana Perinatal Commission to make sure 17P is available (17P is progesterone medicine that can help prevent preterm birth in some pregnant women who have already had a preterm birth).

Additionally, MoD is partnering with LDH to address health equity head-on in the Shreveport area. In 2015, Shreveport had the highest preterm birth rate among the 100 U.S. cities where the most babies are born. MoD's Healthy Babies are Worth the Wait® is partnering with City MatCH's Institute for Equity in Birth Outcomes to address health disparities relating to birth outcomes with emphasis on prematurity, birth spacing, infant mortality, social determinants of health and health access.

EXPANDED HOME VISITING PROGRAMS

National research shows that home visiting results in improved prenatal health. To prevent preterm births, Minnesota has expanded its home visiting program. Minnesota has successfully supported the start-up or expansion of home visiting programs in four tribal nations and more than 70 counties over the last two years. This state grant funding was authorized by the 2017 Legislature and signed into law. MDH currently oversees \$35.7 million in federal and state funding to support home visiting services across Minnesota with 95% of counties and 81% of tribes implementing evidence-based home visiting programs.

DOULAS FOR DADS

Ramsey County is the home of St. Paul and Minnesota's second most populous county. The Ramsey County Birth Equity Community Council is a public-private collaborative focused on racial healing and public health strategies to reduce inequities in birth outcomes. After community conversations, it became clear that though there was some support for moms, dads were left out of efforts addressing higher infant and maternal mortality rates for black babies and moms. The group decided to start Doulas for Dads. The idea was that by training men to become certified doulas and lactation educators, they would also become advocates for women and infants when dealing with medical systems and medical providers. A total of 10 men have been trained as certified perinatal educators as of July 2019.

INFANT MORTALITY AMONG AFRICAN AMERICANS PROJECT

Hennepin County has the largest concentration of African Americans in Minnesota. The infant mortality rate in the county among U.S.-born African Americans is 3.4 times higher than whites. The Infant Mortality among African American Project acknowledges that the difference in the infant mortality rate goes beyond maternal characteristics, behaviors and access to health care, and is influenced by other factors including social issues and individual and family circumstances.

To address this complex issue, the Minnesota Department of Health is using a community engagement model that brings together the perspectives of the community through a Health in All Policies approach. The health department formed a Community Voices and Solutions leadership team to guide the 5-year project that is funded through 2020. The leadership team consists of about 20 members representing community groups, grassroots organizations and local and state health departments. The team is currently working together to determine key conditions and barriers contributing to health inequities. The group has hosted a summit to develop a sustainability blueprint for addressing U.S.-born African American infant mortality, proposed strategies for addressing U.S. born African American infant mortality and hosted two rounds of community co-learning sessions that resulted in four community action teams.

17P QUALITY IMPROVEMENT PROJECT

With Minnesota and the nation as a whole continuing efforts to reduce infant mortality, the Minnesota Department of Health is highlighting the value of progesterone to prevent preterm births. The most effective strategies for a woman who has already had a premature infant is a series of progesterone shots called 17P. The health department and other partners have been working with Minnesota clinics to get this important treatment to expecting mothers. The 17P Quality Improvement Project started in 2016 is focused on educating providers, identifying women for the treatment, addressing barriers and sharing best practices for helping expecting mothers complete the series of shots.

Minnesota clinics have already seen success with 17P implementing national guidelines from The American College of Obstetricians and Gynecologists and The Society for Maternal-Fetal Medicine. Results from clinics in Minnesota are consistent with national research findings that the progesterone injections can help prevent premature births. The effort to increase the use of 17P is supported by a coalition of partners formed in 2016. The partnership includes the Minnesota Department of Health, Minnesota Perinatal Organization, Minnesota Prematurity Coalition and March of Dimes.

The Minnesota Perinatal Quality Collaborative established in 2018 seeks to improve maternal and infant health outcomes with emphasis on racial and ethnic health inequities. It is facilitated by the Minnesota Department of Health and the Minnesota Perinatal Organization. The next cohort of the 17P project will be guided by collaborative members and 17P faculty within the MNPQC.

NORTH DAKOTA

SUMMARY STATEMENT

During the past ten years, the pregnancy smoking rate for North Dakota women has steadily declined from 17.0% in 2009 to 11.0% in 2018. Through evaluation from the BABY & ME – Tobacco Free Program (BMTFP) and North Dakota Vital Records data, the average birth weight of babies born to women in the BMTFP compared to the average birth weight for pregnant smokers is statistically significantly higher. In fiscal year 2017, the difference was 8 ounces, and in fiscal year 2018, it was 6.5 ounces.

The BMTFP is an evidence based, smoking cessation program created to reduce the burden of tobacco on the pregnant and postpartum population. By providing counseling support and resources to pregnant women, the program helps women quit smoking and stay quit, resulting in improved birth outcomes and long-term positive outcomes for women, children, and their families. In the postpartum sessions, women receive continued support to maintain their tobacco free lifestyle as well as diaper vouchers when they test tobacco free.

ACTIVITIES AND RESULTS

Increased education and program outreach had a positive effect on birth outcomes. During the recent year, the North Dakota Department of Health (NDDoH) funded several Tobacco Treatment Specialist (TTS) trainings, which resulted in an additional 90 staff from a variety of healthcare settings with increased tobacco treatment and motivational interviewing skills. Improved documentation of tobacco use and cessation interventions contribute to reducing tobacco use at any age, especially important to women of child-bear age.

The BMTFP increased promotion and outreach within each location's community. BMTFP facilitators shared program information and participants' successes with other local service locations to spread awareness of the resource for pregnant tobacco users. A majority of the BMTFP sites are based in health care systems with additional sites at local public health units and a federally qualified health center. This year, the NDDoH expanded the BMTFP into rural and American Indian locations. Additionally, the BMTFP enrollment increased 45% this year.

SUMMARY STATEMENT

National Vital Statistics System data on Nevada rates of prenatal care beginning during the first trimester increased from 66.8% in 2011 to 74% in 2017. Nevada Title V Maternal and Child Health (MCH) Program efforts to promote adequate and early prenatal care to reduce preterm births include maternal and infant-specific epidemiological surveillance, identification and reduction of health disparities, and increasing access to prenatal and antenatal care services.

ACTIVITIES AND OUTCOMES

Title V MCH staff participate in collaborative projects to reduce preterm births, including the Go Before You Show media campaign to increase public awareness of the importance of accessing prenatal care in the first trimester. This campaign was launched in response to Title V MCH-funded Fetal Infant Mortality Review recommendations.

Nevada's Infant Mortality Collaborative for Improvement and Innovation Network (IM CoIIN) project focuses on Social Determinants of Health and reducing preterm births. It includes participation of local health authorities, March of Dimes, Nevada Home Visiting, and the Division of Health Care Financing and Policy (Medicaid). CoIIN efforts resulted in policy changes to better promote Medicaid coverage of alpha hydroxyprogesterone caproate (17P) to increase appropriate utilization and a provider-focused Project ECHO webinar on 17P.

Title V MCH perinatal quality efforts focus on improving preconception and interconception health among women of childbearing age (ages 15-44). Promotion of Long Acting Reversible Contraceptive (LARC) use and education on reimbursements for LARCs now being covered at the time of delivery and immediately postpartum via reimbursement factsheets are shared widely. Title V MCH co-funded Home Visiting Programs promote birth spacing, well visits, screenings, and access to services. Title V MCH-led partnerships to reduce early elective deliveries include the Hospital Recognition Program with the Nevada Hospital Association and March of Dimes. Three Nevada hospitals were recognized for efforts to reduce rates of early elective deliveries by 5% for two consecutive quarters in 2015; in 2016, 12 Nevada hospitals were recognized.

Title V MCH's priority to reduce substance use during pregnancy and reduce children's exposure to secondhand smoke resulted in all Title V MCH-funded partners being required to promote and refer eligible women to the Nevada Tobacco Quitline and the Title V MCH program-funded website <http://sobermomshealthybabies.org/>. A media campaign promoting the website and priority admission for pregnant women at state-funded treatment centers continues to be distributed to partners statewide, and a Substance Use During Pregnancy Provider Toolkit was created and distributed widely, including tobacco cessation during pregnancy resources. Continuing current activities and trends to increase early and adequate prenatal care will promote health equity, reduce preterm birth rates and associated disparity ratios, along with formalizing emerging state perinatal quality collaborative efforts.

SUMMARY STATEMENT

The New Jersey Department of Health (DOH) is committed to improving birth outcomes and addressing disparities in infant mortality and morbidity. Prematurity is a leading cause of infant mortality and morbidity. Preterm births can result in devastating health outcomes as well as emotional and economic impacts. In New Jersey, Black women are more likely to have preterm births. According to the 2015-2017 NJ birth certificate data, the preterm birth rate for Black non-Hispanic women was 13.3%, compared to White non-Hispanic of 8.5%, Hispanic of 9.9% and Asian non-Hispanic of 8.8%. Through several initiatives, DOH is working to improve community-based programs and provide quality access to preconception, prenatal, and inter-conception care for women and reduce health disparities in birth outcomes, including black infant mortality (BIM).

ACTIVITIES AND RESULTS: NURTURE NJ

Nurture NJ is the First Lady's statewide awareness campaign that is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The campaign, which is devoted to serving every mother, every baby, and every family, includes a multi-pronged, multi-agency approach to improve maternal and infant health among New Jersey women and children. Nurture NJ includes internal collaboration and programing between departments and agencies; an annual Black Maternal and Infant Health Leadership Summit; the First Lady's Family Festival event series; and a robust social media strategy to inform and raise awareness.

HEALTHY WOMEN HEALTHY FAMILIES INITIATIVE: CENTERING

The DOH Healthy Women Healthy Families (HWHF) initiative, launched in July 2018, was developed to improve pregnancy outcomes and address the high rates of BIM in counties and municipalities. It uses Community Health Workers to provide intensive, personalized support to women and their families throughout pregnancy. It includes doula and breastfeeding support, fatherhood initiatives and Centering Pregnancy, an evidence-based model of group prenatal care designed to empower women and improve birth outcomes. On August 9, 2019, Governor Phil Murphy signed legislation extending Medicaid prenatal care coverage to Centering Pregnancy, a model where pregnant women receive health assessments, social, clinical and educational activities in a group setting.

DOULAS

Doulas are trained to provide physical and emotional support and education to help women through pregnancy, birth and beyond. Studies show doulas reduce the likelihood of cesarean births, increase the probability of vaginal births, and provide a more positive childbirth experience. Fatherhood initiatives engage the support and involvement of fathers during prenatal care, birth, and inter-conception care, as well as promote family engagement. Breastfeeding support includes lactation consultants and peer counselors to educate and support women using a culturally sensitive approach.

The Doula and HWHF programs target high-risk populations, which includes those who are low-income and/or uninsured women with chronic health conditions and multiple social or economic stressors, victims of domestic violence, those impacted by mental health issues, alcoholism and substance abuse, women with minimal social supports and women with unintended pregnancies. These women on average attend fewer prenatal visits and are more likely to experience adverse birth outcomes including prematurity.

FAMILY PLANNING

DOH is increasing efforts to help prevent preterm births by increasing access to family planning options through the restored and continued Family Planning funding. To reduce unintended pregnancies, DOH is increasing access to all contraceptive methods, including long-term, reversible contraception (LARC). LARC options include intrauterine devices (IUDs) and implants and are among the most effective methods of contraception according to the CDC. Additionally, the Family Planning funding supports access to contraceptive counseling, which promotes shared decision making between patients and their providers so patients can elect to use the contraceptive method that best fits their lifestyle and reproductive health needs. By prioritizing funding for family planning and reproductive healthcare services, DOH is working to ensure that women have access to vital healthcare throughout every stage of their reproductive lifecycle.

17P

A medication called 17-alpha hydroxyprogesterone (17P) is proven to prevent preterm births in certain women. The 17P/Prematurity Prevention Initiative established a leadership team to provide consultation, analysis, and guidance. Gaps were identified in medical practices that present barriers for women most at risk of preterm birth. These factors impact Black, Hispanic, uninsured, and undocumented women disproportionately. The DOH and its grantee Family Health Initiatives (FHI) uses a multi-dimensional strategy to support the clinical needs of mothers with a history of preterm delivery that (1) provides education and awareness to the community and women most impacted by high preterm births about the availability of effective interventions for preterm births; (2) educates community program staff about support available to clients; (3) enlists doctors, nurses, midwives, and hospitals in identifying these women; and (4) assists medical providers by streamlining the process for quick access to the medication regardless of their socioeconomic or racial/ethnicity status.

To broaden the dissemination of information in a format that is readily accessible to women around the state, the Prematurity Prevention Initiative produced an educational video highlighting the stories of two African American women with preterm birth experiences. Their stories provide answers to many common questions and concerns. The video, produced in Atlantic County, will be available on social media and in physician offices to educate people on the availability of 17P as an evidence-based intervention. Also, in Atlantic County, FHI worked with South Jersey Medical Center, the area's Federally Qualified Health Center, to identify and track women eligible for 17P medication based on previous pre-term birth experiences. The health center established a High-Risk Committee, which conducted a weekly review of eligible women.

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH- INCREASING ACCESS TO CARE

The multi-agency Maternal and Infant Health (MIH) Committee recognized the need to remove transportation as a barrier to women receiving weekly injections or attending prenatal appointments. As a result, once women are determined to be eligible, they can contact NJ Transit Access Link, which picks them up at home and transports them to medical visits, grocery stores, and other locations.

New Jersey is tracking the impact this service has on improving pregnancy outcomes to highlight the strength of this innovative strategy. Meanwhile, the Murphy Administration has worked to stabilize New Jersey's health insurance system through preserving minimum essential coverage and a state-level shared responsibility payment and pursuing a state-based health insurance exchange.

MATERNAL MORTALITY AND MORBIDITY

Maternal and infant outcomes are intertwined. NJ has among the worst pregnancy-related mortality, severe maternal morbidity, and disparities outcomes in the country. To change course, Governor Phil Murphy signed a law in May 2019 that implements the New Jersey Maternal Care Quality Collaborative, New Jersey Maternal Mortality Review Committee, and New Jersey Maternal Data Center to ensure that all relevant health systems and stakeholders are learning from the evidence and pursuing data-driven solutions to avert preventable deaths and injuries. NJ is also implementing laws including the Report Card of Hospital Maternity Care, promotion of shared decision-making, screening through the Perinatal Risk Assessment, and prohibition on coverage for non-medically indicated early elective deliveries.

UPCOMING CONFERENCES

FHI and NJ DOH are collaborating with the NJ March of Dimes to host a November 12th Prematurity Awareness month media event to share outcomes of the 17P collaboration and to increase consumer awareness of the importance of 17P to reduce repeat preterm birth. Also, the Department of Health's 2019 Population Health Summit on September 23, 2019—entitled Maternal Outcomes Matter—will feature state and national expertise on maternal and infant health, with special emphasis on eliminating disparities, innovative services, and data-driven action.

SUMMARY STATEMENT: CELEBRATEONE

The goal of the CelebrateOne Community Connector Corps is to connect disconnected women to reliable medical and social services that will lower the infant mortality rate in eight priority Columbus neighborhoods where infant mortality is highest.

To address the needs of the community and connect pregnant and parenting women/families to supportive services, the program identifies and trains local residents as community health workers (CHWs). The CHWs work within these targeted neighborhoods with the goal of reducing prematurity and infant mortality. To accomplish this, neighborhood-based CHWs:

- **Identify and engage** women and families to schedule prenatal/primary care appointments through community outreach and canvassing.
- **Refer** women to supportive services that address social determinants of health and the preparation for the arrival of a new baby (cribs, diapers, and home visiting) so that women can focus on their health and their family's well-being.
- **Follow up with families** to make sure they are connected to services and that barriers or access issues experienced by the families are documented and addressed.
- **Inform** community partners about gaps in services for residents.

Since the first full year of program implementation in 2016, the infant mortality rate within the eight priority neighborhoods decreased from 11.8 deaths out of 1,000 live births to 10.4 deaths out of 1,000 live births in 2018.

CRADLE CINCINNATI

Because it is the leading cause of infant death, reducing extreme preterm birth is a major focus of Cradle Cincinnati in Hamilton County. Over the past five years, the county has seen a 12% decline in extreme preterm births. Encouragingly, the bulk of that improvement has come from a 55% decline in just three neighborhoods where the collaborative has focused its energy and resources. Those communities were home to 81 extreme preterm births between 2009-2013 and just 36 from 2014-2018. This place-based approach, called Cradle Cincinnati Connections, is led in partnership with moms from each neighborhood. The work is focused specifically on improving African American preterm birth rate outcomes and has five central tenants:

1. Find and deliver measurable results for every woman in a geographic place.
2. Build trust and empathy through consistency of care and sustained, authentic connection developed by a CHW and nurse case manager team.
3. Solve the problems of each mom by "saying yes" and providing tangible resources.
4. Develop unique, community-driven solutions and strategies.
5. Reinforce our stakeholders' sense of ownership with place-based motivation and data about impact.

In partnership with bi3, the state of Ohio and Health Resources and Services Administration, Cradle Cincinnati Connections is currently expanding to reach 12 zip codes.

FIRST YEAR CLEVELAND

First Year Cleveland has a goal of reducing Cuyahoga County's infant mortality rate (IMR) of 10.5 to 6.0 in 2020 from a high of 10.5 in 2015. They are mobilizing the community through action teams and a unified strategy centered on reducing racial disparities, addressing extreme prematurity, and eliminating sleep-related infant deaths. Early efforts are encouraging with an over 20% decrease in Cuyahoga County's IMR over the period of 2015-2017 proving that success is possible, although their work is not done. Preterm birth is the leading cause of infant deaths in Cuyahoga County and in African American births. First Year Cleveland is committed to implementing an equity lens throughout its work and addressing structural racism in order to achieve system changes and better health outcomes.

SUMMARY STATEMENT

Oklahoma has made improvements in infant mortality, prematurity, and related areas in the last several years. Infant mortality has decreased from 8.6 deaths per 1000 live births in 2007 to 7.1 in 2018. Additionally, in collaboration with March of Dimes, non-medically indicated early elective deliveries were reduced by 96% from 6.1% in 2011 to .02% in 2014 through the Preparing for a Lifetime Every Week Counts initiative. Additionally, the rate was reduced in half from 2014 to 2017 (from 4% to 2% CMS PC-01 rate) under the Every Week Still Counts program initiative designed to hold the gains made.

ACTIVITIES AND RESULTS

The Preparing for a Lifetime: It's Everyone's Responsibility (PFL) Every Week Counts (EWC) initiative contributed to a 96% decrease from 2011 to 2014 in the number of non-medically necessary scheduled deliveries (also known as early elective deliveries or EEDs). This was significant as Oklahoma went from having eight early elective deliveries per day to averaging only one EED every 3.5 days!

Major components of this initiative included:

- Creating the EWC collaborative team among birthing hospitals and establishing a voluntary "hard stop" policy on early elective deliveries;
- Educating patients on the risks of preterm and early-term births using materials from March of Dimes; and
- Initiating public service announcements to raise public awareness of the risks of birth prior to 39 weeks.

About 95% of the state's birthing hospitals (52) participated in the PFL Every Week Counts initiative, and this engagement was critical to the initiative's success. Timely data and reporting from hospital partners was essential because it allowed the EWC initiative to provide quarterly reports on hospitals' progress and compare outcomes among hospitals. The collective effort of these partners produced a statewide quality improvement initiative that decreased early elective deliveries in the state of Oklahoma considerably.

To maintain the gains made through this highly successful initiative, the Every Week Still Counts campaign was implemented to monitor the continued progress on this initiative under a new measure that hospitals have been required to submit data on early elective deliveries through CMS utilizing the Joint Commission's National Quality Core Measure in Perinatal Care, Elective Delivery (PC-01). This measure indicates that Oklahoma continues to decline EEDs by approximately 50% from 2014 to 2017.

The state PFL Every Week Counts and Every Week Still Counts initiatives demonstrate that through shared vision and collaboration amongst state leaders, community partners and committed champions--a positive impact in the lives of Oklahoma's mothers, babies, and families can be made.

SUMMARY STATEMENT

The mission of the Pennsylvania Department of Health (Department) is to promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality healthcare for all Commonwealth citizens. When addressing the health of Pennsylvania's infants and reducing preterm birth, the biological, social, environmental, and physical factors influencing maternal and infant health must all be considered. To optimize outcomes, women need to be healthy physically and mentally before, during and after pregnancy. While national gains have been made in reducing infant and maternal morbidity and mortality, the U.S. rates are still higher than most other industrialized nations despite major advances in medical care. Additionally, racial disparities persist with the risk of preterm births for black women one and a half times higher than those of white women in Pennsylvania. The Centering Pregnancy model of care has shown positive effects on mental health, prenatal knowledge, and health related behaviors to improve birth outcomes.

ACTIVITIES AND RESULTS

The Department, in collaboration with March of Dimes, the Children's Hospital of Philadelphia Research Institute Policy Lab and the Pennsylvania Department of Human Services, has developed a pilot program to help prevent preterm births through increased awareness about the use of 17-alpha-hydroxy progesterone caproate (17P). This project aims to identify barriers to receiving 17P and to develop and implement ways to decrease barriers and increase 17P utilization to reduce the preterm birth rate in Pennsylvania.

The Chester County Child Death Review Team established a subcommittee to review deaths among preterm infants. The subcommittee, formed in 2009, has allowed for the analysis of clinical circumstances surrounding the death of premature infants including any medical interventions as well the social, economic and other factors that may have contributed to the death. The subcommittee includes clinicians from local hospitals, public health professionals and service providers. The subcommittee will develop recommendations based upon the data collected from case reviews.

Funded by the Pennsylvania Department of Health, Title V Maternal and Child Health Services Block Grant, Centering Pregnancy Programs (CPP) have been implemented in the cities of Philadelphia and Lancaster, selected because of their disproportionately high rates of poor birth outcomes among women of color. The tables below outline the improvements in the rate of preterm birth and low birth weight for CPP participants compared to non CPP participants. Comparatively, in Pennsylvania for 2015-2017, 9.4% of births were preterm and 8.3% of babies were born at a low birth weight. These positive program outcomes may help to improve the overall health and well-being of both the mother and infant throughout the lifetime.

Lancaster 2015-2017	CPP	Non-CPP
Preterm birth	7.83%	11.67%
Low birth weight	7.00%	7.27%

Philadelphia 2015-2017	CPP	Non-CPP
Preterm birth	8.54%	12.29%
Low birth weight	6.43%	9.80%

Albert Einstein Healthcare Network's CPP in Philadelphia, unlike many other CPP, allows their high-risk patients to participate to gain from the psychological and social benefits of the program. The location allows for direct referrals to a wide range of services including: mental health, laboratory services, domestic violence counseling, transportation, doula services and breastfeeding support. Additionally, the program refers to the Centering Parenting Program to continue this model of care through the child's first two years of life.

Lancaster General Health expanded their CPP in 2018 by adding a group specifically for women with Substance Use Disorder (SUD) to help negate the adverse effects, including an increased likelihood of preterm birth, that SUD has on infants. The sessions are facilitated by a Licensed Social Worker who is certified in Addictions Counseling. The group follows the traditional CPP model of prenatal care but incorporates education specifically related to SUD and pregnancy such as how to calm an infant going through withdrawal, stress management, and what to expect if your infant must stay in the Neonatal Intensive Care Unit. An additional benefit of this specialized group is having a group of women who are in similar circumstances which fosters social support in a safe, judgement free space.

SUMMARY STATEMENT

Smoking during pregnancy can result in numerous adverse birth outcomes including preterm birth and low birthweight, birth defects and infant death. In 2017, an estimated 18.1% of women in South Dakota smoked in the three months prior to pregnancy, and 12.6% smoked while pregnant. Among women who are successful in quitting tobacco during pregnancy, relapse after delivery is common. In 2016, the rate of postpartum relapse among SD mothers was 38.0%. Relapse in the postpartum period poses risks to the infant from second and third hand smoke exposure, as well as continued health risks for the mother. The South Dakota QuitLine is available for all South Dakotans aged 13 and older, including pregnant women, and added a Postpartum Program in June 2016.

ACTIVITIES AND RESULTS

In June 2016, the SD QuitLine launched a relapse prevention program targeting postpartum women. Pregnant women who enroll in the SD QuitLine are invited to enroll in the Postpartum Program during one of the five standard coaching calls. The program consists of four coaching calls (in addition to the five calls offered through the standard SD QuitLine service) completed by a dedicated coach with expertise in postpartum cessation coaching. The additional calls are structured at designated time points based on the woman's due date, including 2 weeks before, and 15, 45 and 90 days after the participant's due date. If at any point while participating in the Postpartum Program, the woman reports a relapse, she is automatically re-enrolled into the standard SD QuitLine Program.

A total of 8,570 tobacco users received cessation services in the SD QuitLine from May 1, 2016 to May 31, 2018. Of these, 147 women (1.7%) indicated they were pregnant, and 46 women (0.5%) were nursing (Figure 1). Of the pregnant women enrolled into the SD QuitLine standard service, 77 (52.4%) also enrolled in the Postpartum Program. Many (60.3%) of Postpartum Program enrollees were not reached, or were no longer interested in participating, at the first Postpartum Program call (2 weeks before due date). Of the 23 Postpartum Program participants, five women reported using tobacco, and opted to re-enroll into the SD QuitLine standard program. Pregnant women enrolled in the Postpartum Program were less likely to be White than the pregnant women who chose not to enroll into the program, and those that enrolled were much more likely to complete at least one coaching session in the SD QuitLine Program (94.7% of Postpartum Program enrollees compared to just 70.4% of non-enrollees). A 31% intent to treat quit rate was calculated, which assumes all participants not contacted for participation in the program are using tobacco.

After seeing early success, the Postpartum Program moved out of the pilot stage in Fall 2018 and expanded to include all pregnant tobacco users who quit during pregnancy, even if they quit on their own. This expanded service has been promoted through Department of Health regional staff, local coalitions, and Medicaid Health Homes providers across South Dakota.

SUMMARY STATEMENT

The infant mortality rate in Tennessee decreased from 7.4 per 1,000 live births in 2016 and 2017 to 6.9 per 1,000 live births in 2018 by targeting interventions across sectors to address root causes. Successful strategies were developed during the infant mortality reduction strategic planning process led by the Tennessee Department of Health (TDH). A statewide, diverse group of stakeholders was convened to develop a plan to reduce infant deaths and specifically addressed strategies to impact preterm birth and health equity.

ACTIVITIES AND OUTCOMES

The Infant Mortality Strategic Planning Committee looked at measures of success to reduce the rate of preterm birth and improve health equity. Some of the strategies in Tennessee include:

1. Decreasing the number of unplanned pregnancies through promotion of client-directed family planning services including Long Acting Reversible Contraceptives (LARCs) and increasing the number of providers utilizing “One Key Question” and Parenthood/Pregnancy Attitude, Timing, and How (PATH) to facilitate reproductive life planning conversation;
2. Decreasing tobacco use by increasing the number of women enrolled in Baby and Me Tobacco Free diaper incentive program;
3. Decreasing early elective delivery through promotion of the BEST (breastfeeding, early elective delivery reduction and safe sleep for Tennessee babies) award to hospitals; and
4. Increasing the number of women participating in group prenatal care. When implementing these strategies, TDH looks at data on health disparities. Areas of the state with high disparities are a focus for prevention efforts.

TDH has collaborated with March of Dimes to implement their group prenatal care model known as Supportive Pregnancy Care in Tennessee. March of Dimes has increased the number of sites and the number of women enrolled in Supportive Pregnancy Care throughout Tennessee. TDH assists clients and providers with a reproductive life plan tools to reduce unintended pregnancies. Births resulting from unintended pregnancies can have negative consequences including birth defects and low birth weight. TDH has increased the number of health departments offering Baby and Me Tobacco Free with all 95 county health departments now participating in the program. TDH has partnered with the Tennessee Hospital Association to promote the BEST award. The BEST award is presented to hospitals annually meeting set criteria around those topics. This is a way to recognize hospitals making strides to reduce infant mortality through promotion of safe sleep, breastfeeding and reduction of early elective delivery.

Tennessee’s example shows that a multifaceted approach with key leaders and stakeholders can be successful in reducing preterm birth and achieving health equity.

SUMMARY STATEMENT

Utah has been focused on building collaborations to reduce the preterm birth rate and improve birth outcomes. Strategies include the Utah Women and Newborns Quality Collaborative (UWNQC) and the Utah Department of Health Office of Health Disparities working with public health resources, health care professionals and community partners to focus on the issue and provide education on preterm birth risk reduction.

ACTIVITIES AND RESULTS

The Utah Women and Newborns Quality Collaborative (UWNQC) is a state-wide network of professionals, hospitals and clinics dedicated to improving the health outcomes for Utah women and babies using evidence based practice guidelines and quality improvement processes. The UWNQC Preterm Birth Committee focuses on reducing the incidence of recurrent spontaneous preterm births by increasing provider discussions with eligible women on the appropriate use of progesterone. The committee, led by a board certified physician in both Obstetrics and Gynecology and the subspecialty of Maternal-Fetal Medicine consists of clinicians and public health professionals statewide. Resources developed include a Preterm Birth Prevention Video Series to educate providers and to provide resources about prevention and What to do After Preterm Birth Guide for Families, available in English and Spanish. Participating hospitals report data on progesterone with some incorporating data collection of progesterone use into their Electronic Health Record.

The Utah Department of Health (UDOH) Office of Health Disparities (OHD) pioneered efforts in data-disaggregation of their Asian and Native Hawaiian/Pacific Islander (NHPI) communities. This uncovered several birth outcomes disparities for NHPIs compared with Utah overall, including a higher rate of premature births. At that time, no health promotion interventions existed in Utah or the U.S. tailored to Pacific Islanders to address this and other birth outcomes disparities. Since 2010, the OHD in collaboration with public health and health care professionals and community partners has been working to address this issue. One product of these efforts is the It Takes a Village: Giving our babies the best chance (ITAV) project. ITAV raises awareness and educates NHPI families and community members about maternal and infant health in the context of Pacific Islander cultural beliefs and practices. Content from the workshops includes preconception health, prenatal care and birth spacing, which work towards addressing this disparity. ITAV is one of the outcomes of a birth outcomes disparities project that was originally rooted in the theoretical framework from the National Partnership for Action to End Health Disparities. In October 2018, the ITAV project became a Promising Practice in AMCHP's Innovation Station, with the recommendation to pursue the designation of Best Practice, which the OHD is currently working toward.

Utah's example shows that collaboration with stakeholders including clinicians and community organizations and creating resources specific to populations with birth outcome disparities has assisted with meeting the Healthy People 2020 goal of reducing preterm births to 9.4%.

SUMMARY STATEMENT

The Virginia Department of Health (VDH) is capitalizing on newly announced statewide initiatives to significantly impact maternal and infant outcomes in the Commonwealth. On June 5, 2019 Governor Ralph Northam announced the goal to eliminate racial disparity in Virginia's maternal mortality rate by 2025, and as direct result, on July 1, 2019 the Virginia Department of Medical Assistance Services (DMAS) announced the Health Birthday Virginia initiative to end maternal and infant mortality through a health equity lens and to ensure all mothers and their infants celebrated the child's first birthday together. The VDH shares these visions and the future will highly focus on leveraging existing activities to increase collaboration, form new partnerships, plan and implement cross-cutting and innovative measures to achieve the goals set forth.

ACTIVITIES AND RESULTS

By December 2025 VDH aims to decrease the disparity in black-white infant mortality disparity ratio from 2.2 (2017) to 1.24 (2025). VDH already travels many avenues addressing maternal and infant mortality, internally and externally, with sister agencies and community stakeholders to evaluate and address indicators along the reproductive life course. Efforts center on continuing engagement with the Virginia Neonatal Perinatal Collaborative (VNPC), a public-private partnership recognized by the CDC & NICHQ as a State Perinatal Quality Collaborative, and whose work has focused on the implementation and promotion of hospital based quality improvement activities. These include several levels of intervention, from surveillance to clinical practice improvements across the state and are focused on Neonatal Abstinence Syndrome (NAS), Maternal Opioid Use Disorder (OUD), Obstetric Hemorrhage and severe hypertension in pregnancy. These activities are occurring in almost 100% of Virginia's birth hospitals.

Also, increased engagement with sister agencies and community based organizations (CBOs) will assist in innovative public health policy initiatives. VDH is participating in DMAS's Policy Innovations Program (PIP) to gain insight as to how public and private agencies and systems can coordinate primary and secondary preventative approaches to improve monitoring and tracking of service delivery and outcomes of pregnant women with substance use disorder. VDH will continue to utilize its federal funding in many of its core programming as well. Focused efforts in safe sleep, unintended pregnancy, substance use and access to care are ongoing in all of its thirty five health districts and Home Visiting partnerships will aid in current agency and state strategic planning to ensure improving maternal and infant outcomes, including reducing preterm birth.

Infant mortality is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health promoting resources. VDH welcomes the Governor's initiatives to further statewide collaborations and to highlight the agency's commitment to ensuring health equity among the Commonwealth's moms and babies.

SUMMARY STATEMENT

Addressing birth outcome health disparities is a priority for the governor, state government, and Washingtonians, and is tracked as part of the state's Results Washington performance management system. Washington has met the Healthy People 2020 objective to reduce total preterm birth to no more than 11.4 per 100 singleton births, however, significant disparities remain in preterm deliveries for racial/ethnic and low income groups.

Our state can successfully reduce population-based disparities through culturally appropriate efforts that address social determinants. In July 2019, Washington State Department of Health launched the Birth Equity Project. Four grantees will engage in a three-year project to use evidence-based/evidence-informed programs or community-informed practices that are culturally appropriate and focus on the root causes of inequities.

ACTIVITIES AND RESULTS

Cross-agency collaboration and engagement with partners across the health system is how we are working toward a state where healthy moms, dads, and babies can thrive. Among the activities:

The Birth Equity Project will support local hospitals and tribal clinics in focusing on enhancing prenatal resources and linkages through such approaches as home visiting, a Centering Pregnancy program, and prenatal yoga classes with an emphasis on expanding access in rural and tribal communities. In urban areas, partner organizations will launch the Culturally Responsive Integrated and Strength-based Parenthood (CRISP) support group, particularly reaching pregnant people and families from American Indian/Alaska Native and Pacific Islander communities, as well as support expansion of doula services for African American women.

The state is addressing the maternal/child impact of the opioid epidemic that is leading to premature births by expanding access to medication-assisted treatment, and expanding residential treatment to allow more women to bring their newborn with them into treatment.

The state offers expanded Medicaid and Medicaid during pregnancy for undocumented women. Our states' Medicaid program covers preventive care use of folic acid for all women of child bearing age, travel vouchers to get to appointments, and full parity telemedicine coverage for both medical and mental health appointments.

Washington State passed legislation to raise the age to buy tobacco and vaping products from 18 to 21. The law is expected to prevent tobacco use and addiction starting in the critical teen and young adult years, which we anticipate will have a positive impact on birth outcomes as we see a decline in smoking prevalence among pregnant women. By partnering on multi-agency initiatives our state is building healthier communities through regional collaborations and improving services that address social determinants.

SUMMARY STATEMENT

Prematurity is the second leading cause of infant deaths in the District, accounting for 12.5% of infant deaths in 2015-2016. In DC, during 2015-2016, the percentage of preterm live births among Black women (12.8%) was significantly higher than white women (7.8%). The rates of preterm birth is also significantly higher (26.9%) for births to mothers who did not initiate prenatal care compared to mothers who initiated prenatal care during their first trimester (10.2%). For mothers with a previous preterm, nearly one-third (31.5%) experienced a subsequent preterm birth in 2015-2016. Medicaid data for Fiscal Years 2015-2016 shows that only about 16% of District pregnant women with a previous preterm birth received 17 alpha-hydroxyprogesterone caproate (17P), a medication that can prevent the recurrence of preterm births by 33%. Through collaboration with local hospitals and federally qualified health centers, DC Department of Health (DC Health) has identified and begun implementing strategies to ensure women who are at risk for preterm birth are offered evidence-based, high quality care. Two hospitals and two federally qualified health centers, serving large portions of publically insured Black women, are creating sustainable systems approaches to preterm birth reduction through clinical quality improvement initiatives. The initial phase of this project focuses on improving the identification of eligible women and streamlining the administration of 17P. Subsequent phases of the project plan to increase the use of aspirin when indicated to prevent preeclampsia and early engagement in prenatal care.

ACTIVITIES AND RESULTS

During the initial phase DC Health, the healthcare organizations and the Department of Healthcare Finance (DHCF) reviewed existing processes for screening for and administering 17P within their respective institutions. This exercise allowed the team to identify and resolve barriers to use of 17P. For example, the team identified varying prior authorization requirements among managed care organizations (MCO) that contributed to inefficiencies for providers and patients. With the state Medicaid agency at the table (DHCF), the groups' efforts led to removal of prior authorization requirement for all MCOs, a practice consistent with the District's Fee-For-Service Medicaid program. This has facilitated more timely and streamlined ordering processes among clinical providers. One health center lacked capacity to monitor and coordinate referrals, and track outcomes for women eligible for 17P. Borrowing a best practice from another health center on the team, the center added a Perinatal Care Coordination Specialist to their team. This has led to improvements in their clinic workflow, including routine patient screening and 17P administration.

As a clinical quality improvement project, each facility is tracking their progress and implementing both standard routine practices and unique innovative approaches to achieve a number of measureable outcomes related to reducing preterm birth. For example, one provider organization is exploring ways to leverage data from their existing electronic medical record to better identify and track women by using a mobile app. Another is exploring the use of social marketing campaigns to target the lack of perceived risk of preterm birth among District women.

This two-year pilot project seeks to demonstrate that collaboration between public health, public insurance, and clinical medicine (birthing hospitals and community obstetric providers), and implementation of scalable clinical quality improvement strategies can reduce occurrence of preterm deliveries among District women at greatest risk.

**HEALTHY
MOMS.
STRONG
BABIES.**

